Iowa Physician Health Program
400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6006 www.iphp.iowa.gov

VERIFICATION OF MEDICAL CONDITION

Treating Physician: Complete and mail this form directly to the Iowa Physician Health Program (IPHP), a program of the Iowa Board of Medicine. Your patient has provided information about a health condition on their most recent renewal application, which has been referred to the IPHP for review. Please note this is a standard practice for anyone that has reported this type of information on their renewal.

This form is also on our website as a PDF document which can be completed using the computer and printing the document. The applicant's signature on this form authorizes the release of information, favorable or otherwise, directly to the IPHP.

Licensee's Name (Print Legibly): ____

Licensee's Date of Birth (Month/Day/Year): ______________________________________

Nature of Medical Condition (Include specific diagnosis):

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Summary of Treatment:

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Treatment Period: **From:** ______________________ **To:** ______________________

Recommended Treatment:

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Is/Was the licensee compliant with his/her treatment? Yes ☐ **No** ☐

If no, please explain.

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Is the licensee taking any prescribed medications for this condition? **Yes** ☐ **No** ☐
If yes, list the medication(s).

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Does the licensee have insight into his/her condition? **Yes** ☐ **No** ☐ If no, please explain.

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Has this medical condition in any way affected the licensee's ability to practice medicine with reasonable skill and safety? **Yes** ☐ **No** ☐
If yes, please explain.

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Do any limitations need to be in place with regard to the licensee's practice of medicine? **Yes** ☐ **No** ☐
If yes, please explain.

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If treatment were to cease for any reason, could the licensee's condition in any way affect his/her ability to practice medicine with reasonable skill and safety? **Yes** ☐ **No** ☐
If yes, please explain.

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Is ongoing monitoring by a treating physician warranted? **Yes** ☐ **No** ☐
If yes, please explain.

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Treating Physician Information

Treating Physician's Name (print legibly):____

Signature:____ **Date:**__________________________

Address:____

Phone:___________________________________

Authorization for Release of Information – Verification of Medical Condition
The licensee must sign this form and submit it with the Verification of Medical Condition form. The treating physician may retain this release of information for their records.

I, ____ (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Physician Health Program (IPHP). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IPHP may include material regarding substance abuse, mental health, and/or HIV/AIDS that is protected by federal and/or state law. **I specifically authorize the release of confidential information to and from the IPHP relating to:**
[x] Substance Abuse or Dependence [x] Mental Health [x] IPHP involvement [x] Other

I further agree that the IPHP may receive confidential information and records, including, but not limited to the following records:

[x] Consultation [x] History & Physical [x] Social History
[x] Assessment/Evaluation [x] Chemical Screening Results [x] Treatment Status
[x] Discharge Summary [x] Psychiatric Treatment [x] Lab, X-ray, EKG
[x] Any information the IPHP deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IPHP pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IPHP, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is effective until the completion of the IPHP review process. I understand I have the right to revoke this authorization in writing, except to the extent that the IPHP has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

____ ________________________

Signature of Licensee **Date**

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as provided in IAC 12.16(6)"b"2, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Revised 2/2/12