4121 Pennsylvania Avenue • Dubuque, IA 52002
P.536.583.4003 F.563.583.4737
www.unifiedtherapy.com

Authorization For Disclosure of Health Information

1. I hereby authorize Unified Therapy Services to disclose the following information from the health records of:

   Patient Name:_____Date of Birth:_____
   Insurance I.D. #:_____
   Address:_____
   Phone:_____

   Covering the period of health care:
   From (date) _____to (date) _____
   From (date) _____to (date) _____

2. Information to be disclosed:
   _____ Physical Therapy _____Occupational Therapy _____Speech Therapy
   - o Complete Medical Records
   - o Monthly Treatment Plan(s) of Care signed by Doctor - (700/701's)
   - o Daily Treatment Notes
   - o Discharge Summary
   - o Other (specify)_____

3. Reason for Disclosure:
   - o Treatment / Continuing Therapy Care
   - o Personal Use
   - o Billing/Claims/Insurance
   - o Disability Determination
   - o School
   - o Other (specify) _____

4. This information will be disclosed to:

Name of Organization or Individual: _____
Address: _____
Phone Number: _____ Fax:_____
Email Address: (optional)_____

Would you like to:
- o Pick up the medical records
- o Have us mail out the medical records: ☐ to you or ☐ to the individual/organization listed above
- o Fax the medical records: ☐ to you or ☐ to the individual/organization listed above
- o Email the medical records: ☐ to you or ☐ to the individual/organization listed above

Comments:_____
_____

5. Does this information need to be disclosed by a specific date? If so, when: _____

*You will receive the medical records no later than 30 days from your request, however, Unified Therapy Services will try to accommodate by your request date.

6. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization, unless otherwise revoked, this authorization will expire one year from the date the Authorization is signed on.

7. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed by (Patient/Guardian):_____Date:_____
Relationship to patient:_____

---------- Office Use – Please Initial ----------

Request taken from: (UTS Staff Member) _____Date:_____
HIPAA Privacy Officer: _____Date: _____
Medical Records copied by: _____Date:_____
*Please remember to document in items sent.
Medical Records sent by: (UTS Staff Member) _____Date:_____