UNIFIED Therapy Services

Authorization For Disclosure/ Release 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. #: _____ Phone #: _____

   Address: _____

   Covering the period of health care:

   From (date) _____ to (date) _____

   From (date) _____ to (date) _____

2. Information to be disclosed:
   Physical ☐ Occupational ☐ Speech ☐ Feeding ☐

   ☐ Initial Evaluation
   ☐ Monthly Treatment Plan(s) of Care
   ☐ Discharge Summary
   ☐ Other (specify) _____

3. Reason for Disclosure:

   ☐ Treatment / Continuing Therapy Care
   ☐ Personal Use
   ☐ Billing/Claims/Insurance
   ☐ Disability Determination
   ☐ School
   ☐ 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:

- ◯ Pick up the medical records
- ◯ Have the medical records mailed: ☐ to you ☐ to the individual/organization listed above
- ◯ Fax the medical records: ☐ to you ☐ to the individual/organization listed above
- ◯ Email the medical records: ☐ to you ☐ to the individual/organization listed above

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.

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: _____

Request completed by (Staff Member): _____ Date: _____

HIPAA Privacy Officer reviewed: _____