



Core Physical Therapy
2001 Westown Pkwy, Suite 107
West Des Moines, IA 50265
Telephone: 515-440-3439
Fax: 515-440-3832

Core Physical Therapy
516 Nile Kinnick Dr. S., Suite B
Adel, IA 50003
Telephone: 515-993-5599
Fax: 515-993-1964

Authorization Form for Release of Confidential Health Information

I, \_\_\_\_\_, hereby authorize Core Physical Therapy to release to:
(Printed Name of Patient or Authorized Agent)

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
(Name of Health Care Facility, Physician, Agency, etc.) (Phone number) (Fax number)
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
(Street Address, City, State and Zip Code)

The following information contained in the patient record of:

\_\_\_\_\_ (Patient's Name)
born \_\_\_\_\_, residing at \_\_\_\_\_
(Birth date) (Street Address, City, State and Zip Code)

Please initial what applies:

\_\_\_\_\_ The entire medical record.
\_\_\_\_\_ Other: \_\_\_\_\_

The above information for the following period of time shall be released: all dates of service if no dates are indicated or from
\_\_\_\_\_, \_\_\_\_\_ to \_\_\_\_\_, \_\_\_\_\_.
(Date) (Date)

The purpose(s) of the authorization is (are) for continued care or for \_\_\_\_\_.

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so.

I understand that I will not be able to revoke this authorization in cases where Core Physical Therapy has already relied on it to use or disclose my health information. Written revocation must be sent to Core Physical Therapy. In the absence of such written revocation, this Authorization for Release of Confidential Health Information will terminate one year from the date signed below or on \_\_\_\_\_(date).

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient: \_\_\_\_\_
(Page 28)