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West Des Moines, IA 50265
Telephone: 515-440-3439
Fax: 515-440-3832

803 Cottage Street
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 Clark Physical Therapy has already relied on it to use or disclose my health information. Written revocation must be sent to Clark 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: _____