DUBUQUE PHYSICAL THERAPY

[ ] Westside Clinic
Dubuque IA
TEL (563) 588-3891
FAX (563)588-3893

[ ] Delhi Clinic
Dubuque, IA
TEL (563)582-4170
FAX (563)582-4181

RELEASE OF INFORMATION AUTHORIZATION

Patient Name: _____ Birthdate: _____

Address: _____

I, the undersigned, do authorize and request Dubuque Physical Therapy, P.C., to release my physical therapy records for the evaluation and treatment (s) that I received from (dates) _____ to _____. This information is to be disclosed for the following purpose:

_____

This authorization is effective for one year from the date signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to an officer of the Corporation.

I understand that I have the right to inspect the information to be disclosed upon proper notification and under the appropriate conditions established by Dubuque Physical Therapy. I acknowledge that information to be released may include material that is protected by states and/or federal law applicable to either mental health and/or drug/alcohol abuse or both.

_____ _____
Signature of patient or authorized representative Relationship to patient

_____ _____
Witness Date

PROHIBITION ON REDISCLOSURE

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