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Dubuque, IA 52002
Phone (563) 588-3891
Fax (563) 588-3893



7462 Thunder Valley Dr
Peosta, IA 52068
Phone (563) 582-4170
Fax (563) 582-4181

REQUEST OF INFORMATION

Patient name _____ Date of Birth _____

Address _____

I, the undersigned, do authorize _____

to disclose the following information _____

_____ from _____.

Please send information to Dubuque Physical Therapy, P.C. for continued treatment.

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 state 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 state law for mental health records, federal requirements (42 C.F.R. Part 2) and state 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 not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.