UCP United Cerebral Palsy of Central Arizona
Life without limits for people with disabilities™

Welcome to UCP of Central Arizona Therapy

Authorization to Disclose Protected Health Information

_____ _____
Child's Full Name Date of Birth

Protected Health Information Authorized to Disclose to UCP of Central Arizona (check all that apply):

____Physician Records ____Hearing/Audiology Reports ____Therapy Prescriptions

____Diagnosis ____Vision Reports ____Therapy Reports

____Diagnostic Testing Results/Reports ____Other (specify):_____

I, _____, give my informed consent for the following medical entity:
Parent/Responsible Party

Medical Entity (Primary Care Physician/Specialist/Hospital/Therapy Clinic)

_____
Name of Person or Agency

_____
Address in Full

_____
Phone Fax

To release and share medical information identified above (in writing and/or conversation) regarding my child with **UCP of Central Arizona**.

Release of Medical Records and Medical Information to UCP of Central Arizona

I have read and understand the conditions of this release. I understand I have agreed to disclose the medical information only to the UCP of Central Arizona, and that the medical entity may not disclose the medical information to anyone else without my prior written consent. I understand that this consent can be revoked at any time but will automatically expire one year from the date of consent.

_____ _____
Name of Parent/Responsible Party Relationship to Child

_____ _____
Signature of Parent/Responsible Party Date

Please send records to UCP of Central Arizona

Via Mail: 1802 West Parkside Lane Phoenix, Arizona 85027 Via Fax: 602-944-1658