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

Consent to Share Records and Information

____ ____________________

Child's Full Name Date of Birth

Records and Information Authorized to Share (check all that apply):

____ Therapy Evaluation Reports ____ Therapy Prescriptions

____ Therapy Daily Notes ____ Medical Records /Docs

____ Therapy Process/Quarterly reports ____Home Programming/Coaching/Strategies

____Other (specify): ____

I, __________________________________, give my informed consent for UCP of Central Arizona to release and
Parent/Responsible Party

Share my child's information identified above (in writing and/or conversation) to the following person/agency:

Person or Agency

____

Name of Person or Agency

____

Address in Full

____

Phone Fax

Release of Records and Information

I have read and understand the conditions of this release. I understand I have agreed to disclose the information only to the person/agency listed above, and that the person/agency may not disclose the 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