TOTAL Kids PEDIATRIC THERAPY

Authorization for Release of Medical Records

Patient Name: _____

Date of Birth: _____

Information to be released by:

Organization/Person Name:

_____

_____

_____

_____

Mailing Address: _____

Phone: _____

Fax: _____

Email: _____

Information to be released to:

Organization/Person Name:

Mailing Address: _____

Phone: _____

Fax: _____

Email: _____

Documents to be Released:: _____

I, the parent or guardian of the patient named above, give TOTAL Kids Pediatric Therapy permission to obtain from or give to the above-named agency/person pertinent information as listed below. I understand that this information is confidential and will only be used for the benefit of this patient. I understand that this information may be subject to re-release by the recipient without the knowledge or consent of TOTAL Kids Pediatric Therapy and that these companies are in no way responsible for this action. I further understand that this consent form is valid for the duration of the patient's treatment, and I may revoke this release at any time by requesting this in writing and submitting it to this office.

Signature of Parent/Guardian: _____
Date: _____

Date: _____