**Authorization to Release Information**

**Patient Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Street Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City/State** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip** \_\_\_\_\_\_\_\_\_\_

I understand this release is voluntary and applies to all programs and services operated under the auspices of Pediatric Therapy Clinic, INC. I understand that my personally identifiable information (PII) may be protected by the federal rules for privacy in the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPPA), and/or other applicable state or federal law and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. **I understand that I may revoke this authorization at any time by notifying Pediatric Therapy Clinic, Inc. in writing but if I do, it will not have any effect on any actions taken before receipt of the revocation.**

**I hereby authorize Pediatric Therapy Clinic, Inc. to (check all that apply):**

\_\_\_ Exchange with \_\_\_\_Release to \_\_\_\_Obtain from **the parties I have indicated below**

**I hereby authorize Pediatric Therapy Clinic, Inc. to exchange/ release / obtain information:**

\_\_\_\_ Verbally only \_\_\_\_ In written form only \_\_\_\_ Both verbally and in writing

**Organization or Individual receiving/communicating the information:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Organization/Individual**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address City, State Zip Phone**

**Description of information to be exchanged / released / obtained:**

\_\_\_\_ Education records \_\_\_\_ Medical records

\_\_\_\_ Evaluation/assessment/eligibility records \_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Clinical records (including physical, occupational, speech, behavior analytic and psychological therapies)

**Duration of release (check one):**

\_\_\_\_ This release will remain in effect for two (2) years, unless otherwise stipulated or revoked in writing.

\_\_\_\_ From \_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY) To \_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YYYY)

**The purpose of this release is:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature of Patient or Legally Authorized Representative Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name and Relationship of Legally Authorized Representative to Patient**