PEDIATRIC THERAPY PARTNERS

640 Enterprise Drive Ste C Lewis Center, Ohio 43035 614.433.0132 www.ptpohio.com

Dear Professional:

The patient named below is going to be seen at ***Pediatric Therapy Partners*** for an evaluation and/or treatment. We would appreciate receiving a copy of your records regarding this client to assist in our comprehensive review and assessment. Below is a release of information signed by the child's parent and/or guardian.

Patient's Name: ____________________________ **Date of Birth:** _____________________________

Guardian's Name: __________________________ **Relationship:** _____________________________

I HEARBY AUTHORIZE THE FOLLOWING PROFESSIONAL AND PEDIATRIC THERAPY PARTNERES TO RELEASE AND/OR SHARE COMPLETE INFORMATION FROM THE MEDICAL, SCHOOL, SOCIAL SERVICE AND/OR PSYCHOLOGICAL RECORD OF THE ABOVE NAMED CLIENT PATIENT TO:

Pediatric Therapy Partners
640 Enterprise Drive, Suite C
Lewis Center, Ohio 43035
www.ptpohio.com
614.433.0132 (phone)
614.866.8840 (fax)

I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that treatment, payment, or eligibility of benefits can not be conditioned on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Name of Professional: ____

Address: ____

Phone Number: ____

Fax Number:____

GUARDIAN SIGNATURE: _______________________________________ **DATE:** ____________

GUARDIAN SIGNATURE: _______________________________________ **DATE:** ____________