Achieve Pediatric Therapy

Occupational Therapy • Independence • **Physical Therapy** • Mobility • **Behavior Therapy** • Life Skills

CONSENT FOR MEDICAL RECORDS RELEASE/REQUEST FORM

Date: _____ Phone: _____

Client Name: _____ Date of Birth: _____

Address: _____

_____

Purpose of Request (Check One)

Release _____ Releasing information from Achieve to you or your provider
Request _____ Requesting information from another provider to Achieve

I authorize Achieve Pediatric Therapy, Inc. to **release/request** *(circle one)* the following:

Information Requested: _____

Purpose of Request: _____

Duration of Authorization:_____

Provider Name: _____

Address: _____

Phone: _____ Fax:_____

- I understand that this authorization shall be valid through_____ *(date)*, or one year from the date of my signature, if end date not specified. I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and copy the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.
- I understand that the release of information may **not** be re-released to any other person or organization without my written consent.
- I understand there is a **$.50 charge per page** for printed copies in addition to provided copies of initial evaluations, re-evaluations, home/school programs and progress updates provided to clients at the time of service.

Signature_____ Date_____

Witnessed by_____ Date_____