ADDRESS:

Beyond Limits Pediatric Therapy Center
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BEYOND LIMITS
Pediatric Therapy Center

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AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THIRD PARTIES

PATIENT NAME: _____ DOB:_____
Address: _____
_____

A) I authorize BLPTC to RELEASE my child's medical records to:

Name: _____
Address: _____
State & Zip: _____
Phone: _____ Fax: _____

B) I authorize BLPTC to OBTAIN my child's medical records from:

Name: _____
Address: _____
State & Zip: _____
Phone: _____ Fax: _____

Please check information that may be released. (Please note that only records that have been ordered by our office will be released.)

_____ All records (will include Audio, ST and OT Evaluations, Plans of Care and Office Notes)
_____ Evaluations
_____ Plans of Care
_____ Office Notes

These records are to be:

_____ Picked up – Please sign for receipt of records: _____
_____ Mailed to: _____
_____ Faxed to: _____
_____ Emailed to: _____
(I acknowledge that I am aware that the email provider is not considered a HIPAA approved secure email provider.)

I hereby authorize this practice to release my medical records, including, but not limited to all of the above. By signing this consent, I completely release the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of such information. I also understand this authorization is only valid for 12 months. However, I reserve the right to revoke this authorization at any time.

SIGNED: _____ DATE: _____

_____ _____
Printed Name Street Address

_____ _____
relationship to patient City, State, Zip Code

_____
contact number

WITNESS: _____ DATE: _____

_____
Printed Name