Release of Information TO/FROM Absolute Pediatric Therapy

I, (parent/guardian name) ____,
hereby authorize:

Absolute Pediatric Therapy to OBTAIN ☐ RELEASE ☐
2713 SE I Street Ste. #5
Bentonville, AR 72712
Phone: 479-250-4355
Fax: 479-553-7954

TO ☐ **FROM** ☐

Name: ______________________________________
Address:_____________________________________
____
Phone: ______________________________________
Fax:____

Information of:
Patient Name:____
Patient DOB and Soc Sec #:____

Information is to the limited to the following dates of treatment (if applicable)
from: _______________ to _______________.

Information requested to be obtained/released:
☐ History & Physical ☐ Evaluation ☐ Treatment Plan
☐ Progress Note ☐ Discharge Summary

Purpose of the obtain/release is:
☐ Personal Files ☐ Continuity of Care ☐ Insurance or Other Payment
☐ Other (explain):____

This Authorization will expire 1 year from the date on which it was signed.
Expiration Date:____________. I understand that I may revoke this authorization at any time by giving written notice. A revocation of this authorization will not apply to records already released.

I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by federal privacy laws and regulations. Treatment, payment, enrollment or eligibility of benefits will not be conditioned on your signing this authorization. I also understand that Absolute Pediatric Therapy has up to 30 days to compile the requested information to be released.

Signature of parent/guardian:__________________________________Date:_____________