Emerge Therapy Services

RELEASE OF INFORMATION TO/FROM EMERGE THERAPY SERVICES

I, (parent/guardian/self name) _____, hereby authorize:

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

Please allow 15 to 20 business days for completion from the date the main clinic location received the request form.

☐ TO ☐ FROM ☐ MAIL ☐ FAX ☐ PICKUP ☐ DISCUSS WITH

Recipient Information

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Client Information

Patient Name: _____

Patient DOB and Soc Sec #: _____

Information is to be limited to the following dates of treatment (if applicable) from _____ to _____

Records Requested are for the following services:

☐ Occupational Therapy, Physical Therapy and Speech Therapy ☐ Mental Health Therapy

Information requested to be obtained/released:

☐ History & Physical ☐ Evaluation ☐ Treatment Plan ☐ Discharge Summary

Purpose of the obtain/release is:

☐ Personal Files ☐ Continuity of Care ☐ Insurance or Other Payments

☐ Other (explain): _____

This authorization will expire 1 years 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 that 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.

_____ _____

Signature of parent/guardian/self Date