

Authorization for Release of Information

Patient: _____

Date of Birth: ____/____/____

I hereby authorize and request Special Needs Pediatric Therapy Services to release my child's treatment records and/or progress reports to the following persons/institutions:

Referring Physician

(Physician's first and last name)

(Street Address)

(Practice Name)

(City, State, Zip)

(Phone Number)

Specialist (ie...neurologist, orthopaedist)

School-Based Therapist (PT, OT, ST)

(Name)

(Name)

(Practice Name)

(School Name/County)

(Phone Number)

(E-mail or Phone Number)

School-Based Therapist (PT, OT, ST)

School-Based Therapist (PT, OT, ST)

(Name)

(Name)

(School Name/County)

(School Name/County)

(E-mail or Phone Number)

(E-mail or Phone Number)

I understand that evaluations/re-evaluations will be released to my referring physician as they are performed, and that progress reports will be released twice per year unless otherwise requested.

Parent/Legal Guardian Signature _____ Date _____

I authorize the release of any information necessary to process insurance claims.

Parent/Legal Guardian Signature _____ Date _____

I hereby authorize my insurance carrier to issue payment of benefits directly to Denise M. Hoell, PT, d/b/a Special Needs Pediatric Therapy Services. I recognize that certain charges may not be covered by my medical insurance and that I am financially responsible for all charges incurred.

Parent/Legal Guardian Signature _____ Date _____

I further acknowledge that if I fail to disclose changes in insurance coverage in a timely manner, and the failure to disclose this information deems services not covered either with my primary insurance carrier, my secondary or tertiary insurance carrier, or with Medicaid, that I am financially responsible for all charges incurred.

Parent/Legal Guardian Signature _____ Date _____

The above authorizations shall be effective from January 1, 2010 (or from the date of the child's initial visit), until December 31, 2010