

# 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)

**Primary Insurance Carrier:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_ **Policy 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 01/01/ 2011 (or from the date of the child's initial visit), until 12/31/2011*