Authorization for Release of Medical Records/Health Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian: _____ Relationship: _____

Phone: _____ Date: _____

Information to be released:

____ Full Medical Record
____ OT Evaluations/Re-evaluations/Annual Reviews/Progress Notes/Treatment Plans
____ PT Evaluations/Re-evaluations/Annual Reviews/Progress Notes/Treatment Plans
____ ST Evaluations/Re-evaluations/Annual Reviews/Progress Notes/Treatment Plans
____ Other: _____

I, _____, authorize the above information regarding, _____,
(parent/guardian name) (patient name)
my child, to be released verbal or written:

From:

Name of Facility: _____

Address: _____

City: _____

State: _____ Zip: _____

Telephone/Fax: _____

To:

Milestones Pediatric Therapy Services, LLC
2800 S. 2nd St., Suite B
Cabot, AR 72023
501-286-6075 tel
501-286-6175 fax

Information obtained by:

___ Mail
Send to: Milestones Pediatric Therapy Services, LLC
2800 S. 2nd St., Suite B
Cabot, AR 72023

___ Pick-up
Person Picking Up: _____
Relationship to Pt: _____
___ Fax: 501-286-6175

1. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
2. I also 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.
3. Milestones Pediatric Therapy Services, LLC, it's employees, and contracted therapists are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized.
4. I understand that the information in my health record may include private/personal information relating to communicable diseases, behavioral, or mental health services/treatment.
5. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to the above listed facility except to the extent that action has been taken in reliance to this authorization. This authorization expires:
   ___ Only upon written revocation
   ___ 1 year from date signed
   ___ Date: _____

_____ _____ _____
Signature or Patient/Guardian (Relationship) Date Telephone