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Authorization for the Release of Medical Information

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: Click to enter a date.

Address:

General Release: I hereby authorize Capital Kids Occupational Therapy, LLC to release to and obtain from, by any means acceptable (including facsimile machine), copies of the above named patient’s medical records. Reports requested will be specified in the documentation but may include test results, diagnostic and/or laboratory reports from medical consultants and any other written documentation relating to the treatment of the patient during the following dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or one year from date signed.

This release provides permission to/from any of the following individuals or entities:

Name Address Purpose

\_\_

\_\_

\_\_

This authorization shall be valid one year from the date of execution, unless sooner revoked. I understand that I may revoke this authorization at any time, except to the extent that action has been taken reliance upon this authorization. A photocopy of this original form shall be valid and enforceable as the original signed document. I understand that a copy of this form in its entirety will be sent to the above mentioned entities.

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Signature of Client, Legal Guardian or DPOA Date

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Witness Date