THE
PEDIATRIC MOVEMENT CENTER
EMPOWER :: ACHIEVE :: INSPIRE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Name_____ DOB_____

RELEASE INFORMATION TO

Name_____

Address_____

City_____ State_____ Zip_____

INFORMATION REQUESTED (please check)

- o Physical Therapy Evaluation/Assessment
- o Speech Therapy Evaluation/Assessment
- o Occupational Therapy Evaluation/Assessment
- o Physical Therapy Progress Notes
- o Speech Therapy Progress Notes
- o Occupational Therapy Progress Notes
- o Physical Therapy Discharge Summary
- o Speech Therapy Discharge Summary
- o Occupational Therapy Discharge Summary

- o Entire record of services received at the Pediatric Movement Center
- o Other_____

- o By signing below, I authorize the Pediatric Movement Center to obtain and use/disclose the follow protected health information for a period of one year from my signature below.
- o I understand that I may revoke this authorization in writing at any time except to the extent that this authorization has already been acted upon. My written revocation must be submitted to: The Pediatric Movement Center, 1045 Maryland Avenue, Hagerstown, MD 21701.
- o I understant that this authorization is voluntary and that I do not have to sign the authorization as a condition of receiving treatment from the Pediatric Movement Center.
- o I understand that if the organization authorized to receive information is not a health plan or health care provider and if such information is re-disclosed by the recipient, the released information may no longer be protected by Federal privacy regulations but may be protected under Maryland law.
- o I understand that upon request, I may receive a copy of this form.

_____ _____

Parent/Guardian Signature Date

_____

Name (Printed)

1045 Maryland Avenue, Hagerstown, MD 21740 :: Phone 301.739.5437 :: Fax 301.739.7453