**DEVELOPMENTAL PEDIATRIC THERAPY CLINIC**

385 CenterPointe Circle, Suite 1325
Altamonte Springs, FL 32701

## Consent for Release of Medical Information Information

I hereby authorize the Developmental Pediatric Therapy Clinic to release medical information, including evaluations, progress notes, and demographic data, in either written or oral form, concerning the below named person, to those parties as indicated below.

Name of Patient: _____ Date of Birth: _____

( X ) The referring/ordering physician: Name: _____

( X ) The Insurance Company or Third Party Payer of record.

( ) Specialist(s), i.e.: Neurologists, Orthopedists, etc. Specify below:

_____

_____

_____

( ) Medicaid Waiver Coordinator: Name: _____

( ) Other: Specify Name: _____

( ) Other: Specify Name: _____

Information will be released and logged in accordance with Federal Privacy Laws. Information will be released to the referring physician and the Insurance or Third Party Payer you have specified, in order to carry out the normal business activities of providing medical care. Any additional releases must be specifically requested. This release will remain in effect for the above parties until such time that you opt to revoke this authorization. Revocations should be made in writing, and revocation forms will be furnished upon request.

Signature of Patient or Guardian: _____ Date: _____

Relation to Patient: _____