Consent for Release of Medical Records

Patient Name:_____ DOB:_____

I hereby authorize **Move Strong Pediatric Therapy Services** to **release** my medical information to include but not limited to patient evaluation, testing scores and progress notes to the following individual(s) or organization(s) listed below:

NAME:_____
Address:_____
Phone:_____

NAME:_____
Address:_____
Phone:_____

For Move Strong Pediatric Therapy Services TO RECEIVE Medical Information:

NAME:_____
Address:_____
Phone:_____ Fax:_____

I hereby authorize the individual(s) or organization(s) listed above to release medical information from the patient's medical charts to include any previous assessments, evaluations, and or treatments to Move Strong Pediatric Therapy. The information will be used for Therapy assessment, evaluations, and treatments only. Please send information to:

Move Strong Pediatric Therapy Services
548 SE Washington Blvd
Bartlesville, OK 74006 Phone: 918-214-8028 Fax: 918-214-8518

I do understand that this consent may be revoked at any time by written requests submitted to Move Strong Pediatric Therapy Services. I understand my revocation will not affect information previously authorized and released or as a condition of obtaining insurance coverage or payment.

Parent/Guardian Signature:_____ Date:_____
Relationship to Patient:_____