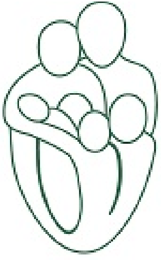

FOCUS Pediatric Therapy

16635 Centerfield Dr, Ste 103, Eagle River, AK 99577

Ph: 907.694.6002 Fax: 907.694.6015

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name____

Date of Birth ____________________________

Person/Organization given permission to receive information

I authorize FOCUS permission to release information to the person/organization listed above concerning:

- ☐ OT Evaluations and Plan of Cares
- ☐ ST Evaluations and Plan of Cares
- ☐ PT Evaluations and Plan of Cares
- ☐ Discharge Summaries
- ☐ All information pertaining to my child's care

I would also like to give FOCUS permission to receive information pertaining to my child's care from the listed person/ organization.

Sign ____

I authorize FOCUS to use or disclose my Personal Health Information (PHI) as described above. I understand that my participation is voluntary and if the organization authorized to receive my PHI is not a health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have the legal right to review our Notice of Privacy Practice. It is available upon request.

Signature of Parent:____Date_____________

Printed Name of Parent:____

Signature of Witness____