



FOR KIDS

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## MEDICAL RELEASE FORM

Patient Name \_\_\_\_\_ Medical Record \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Dynamic Therapy, Inc. is authorized to release or request any medical information which is necessary in providing therapy services for my child from the following agencies.

Pediatrician \_\_\_\_\_

Case Manager \_\_\_\_\_

Other agencies/therapists \_\_\_\_\_

Hospitals/Clinics/Health Departments \_\_\_\_\_

School System \_\_\_\_\_

CDSA \_\_\_\_\_

Others \_\_\_\_\_

I acknowledge receipt of information between Dynamic Therapy For Kids and the above named facilities/agencies. I acknowledge receipt of the Notice of Privacy Practices and understand the conditions under which information will be used and disclosed. I understand the types of information that may be disclosed to the above named persons. I understand that I can add to or remove the authorization of any person at any time in writing to Dynamic Therapy For Kids.

This authorization will be in effect for one year after date of signing.

Signature \_\_\_\_\_ Date \_\_\_\_\_