Dynamic Therapy
FOR KIDS

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MEDICAL RELEASE FORM

Patient Name _____

Parent/Guardian _____

Dynamic Therapy for Kids 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_____