



AUTHORIZATION OF MEDICAL RECORDS RELEASE

I hereby authorize Kid at Heart Therapy, LLC to release or obtain my child's individually identifiable information, including contact information, and information about physical health or mental health, condition, health care or other services, and payment for services, under the circumstances described below. I authorize Kid at Heart Therapy, LLC to:

RELEASE written and verbal information to _____

OBTAIN written and verbal information from _____

Type of Information (specific description, dates): _____

I understand that:

- This authorization will expire one year from the date signed, unless an earlier date is provided: _____
- This authorization must be filled out completely to be valid. A copy is as valid as the original. I am entitled to a copy of this authorization.
- Kid at Heart Therapy will not refuse to provide health care services, based on my refusal to authorize the use or disclosure of my personal health information for a purpose unrelated to those health care services.
- I may revoke this authorization at anytime by notifying Kid at Heart Therapy in writing, but if I do, it won't affect any actions Kid at Heart Therapy took in reliance on this authorization before I revoked it.
- Once information is released to a third party according to this authorization, Kid at Heart Therapy cannot prevent its re-disclosure.
- This authorization does not limit the ability of Kid at Heart Therapy to use or disclose my health information as otherwise permitted by state or federal law.

Print Parent/ Legal Guardian's Name

Relationship to Patient

Signature of Parent/ Legal Guardian

Date

Patient's Name

Patient's Date of Birth