This form allows us to obtain information from your child's physician, school, or other facilities that may have needed medical information pertinent to your child's Plan of Care. (Test results, medical history, etc.)

A DIFFERENT KIND OF PERFECT

ADKOP

PEDIATRIC THERAPY, LLC

Authorization for Release of Information

Office Address
1555 W. Hwy. 380, Suite #2
Decatur, TX 76234

Mailing Address
P.O. Box 2138
Decatur, Texas 76234

To: _____

_____

_____

Phone: _____

Fax: _____

Patient Name: _____ Date of Birth: _____

Date of Service: _____ MCR/SSN: _____

Requested Information:

- o History and Physical
- o Discharge Summary
- o Therapy Note
- o Other: _____
- o Lab/Test Results
- o Progress Notes

Authorization:

I hereby authorize _____ to release medical information to A Different Kind of Perfect Pediatric Therapy. This authorization is for an indefinite period of time. I understand that I may revoke this authorization at any time by written notice to A Different Kind of Perfect Pediatric Therapy.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____