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2019 Records Request Authorization

Child's Name: ____________________________ DOB: ___________________________

In order for providers to be able to communicate with us (and/or each other) regarding your educational and medical file under applicable state and federal law, we need to obtain a hand signed Educational and/or Medical Information Release Form from you.

Educational and/or Medical Information Release Form

The undersigned hereby grants permission to Therapeutic Playtime to discuss any and all medical and educational bill related information with any educational practitioner, medical practitioner, hospital, facility, insurance company or and other agency/entity that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein.
The undersigned hereby authorizes any medical practitioner, hospital, facility, insurance company or any other person or entity that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein, to release such information upon request to interested PARTIES (to be determined by Therapeutic Playtime) for the purpose of communicating with Therapeutic Playtime and/or for providers to be able to communicate with one another regarding your medical file.

The undersigned understands that:

- I may revoke this medical information release at any time, in writing, but the release shall remain valid until revoked or upon the expiration of one (1) year after the release is executed, whichever occurs first.
- This release may include medical records of treatment for physical and/or emotional illness.
- A copy of this form, including a facsimile, may be used in place of the original.

NOTE: Further, I authorize the disclosure of my protected health information in accordance with the terms in this Authorization.
Optional: If it is necessary for someone other than your spouse to discuss your medical bills or finances with Therapeutic Playtime, please provide the individual's name below to appoint and authorize them to act as your personal representative for this limited purpose: ("Personal Representative")

Patient's Name: _________________________

Patient (Or Guardian) Signature: ________________________

Date: ______________________