Bartlesville Hope
Pediatric Therapy

Consent for Release of Medical Record

Patient Name:_____ DOB:_____

I nearby authorize ***Bartlesville Hope Pediatric Therapy*** to **release** my medical information to include but not limited to patient evaluation, testing scores and progress notes to the following individual(s) or organization(s) listed below:

NAME:_____

Address:_____

Phone:_____ Fax:_____

NAME:_____

Address:_____

Phone:_____ Fax:_____

For Bartlesville Hope Pediatric Therapy TO RECEIVE Medical Information:

I hereby authorize the individual(s) or organization(s) listed above to release medical information from the patient's medical charts to *Bartlesville Hope Pediatric Therapy.* The information will be used for Occupational, Physical, and Speech Therapy assessment, evaluations, and treatments only. Please send information to:

Bartlesville Hope Pediatric Therapy
117 W 5th Street LL
Bartlesville, OK 74003 Phone: 918-212-3313 Fax: 1-918-512-4082

I do understand that this consent may be revoked at any time by written requests submitted to Bartlesville Hope Pediatric Therapy. I understand my revocation will not affect information previously authorized and released or as a condition of obtaining insurance coverage or payment.

Parent/Guardian Signature:_____ **Date:**_____

Relationship to Patient:_____