FUNCTIONAL KIDS THERAPY

every child deserves a champion

Communication and Medical Information Authorization and General Release Form

I, (print name) _____ the parent/guardian of_____

agree to allow **Functional Kids Therapy Center** to disclose the following health information regarding my child **to/from** the following providers or facilities as set forth below.

Section 1: HEALTH INFORMATION

☐ My child's complete health records including, but not limited to, examination, diagnoses, treatment, and billing records for all conditions

OR

☐ My child's complete health records, excluding any of the following information: (please specify below)

_____

_____

Section 2: PERSONS WHO CAN RECEIVE MY HEALTH INFORMATION

I authorize **Functional Kids Therapy Center** to share my health information with the following persons:

	Name/Office	Contact #
1.	_____	
2.	_____	
3.	_____	
4.	_____	

I understand that the persons listed above may not be covered by state/federal rules governing the privacy and security of data and may be permitted to further share my health information.

Section 3: DURATION OF AUTHORIZATION

This authorization to share the health information is valid: for 1 year from signature date.

I understand that I am permitted to revoke this authorization to share the health information at any time and I can do so by submitting a request in writing to the office manager at Functional Kids Therapy Center LLC.

However, in the event that the information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health information.

Guardian/Parent Signature: _____ Date: _____