PEDIATRIC THERAPY ASSOCIATES

Providers of Occupational, Physical, and Speech-Language Therapy

"Making a difference each step of the way!"

OFFICES OF HANDS-ON THERAPY, INC. ~ PRYOR PHYSICAL THERAPY, INC. ~ SPEECH SOLUTIONS, INC.
2501 East Moore Avenue, Searcy, AR 72143 ~ Phone: (501) 268-5001 ~ Fax: (501) 268-5443

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME/FACILITY: _____

ADDRESS: _____
STREET ADDRESS CITY / STATE / ZIP CODE

PHONE NUMBER: _____ FAX NUMBER: _____

I, _____, hereby authorize release to
NAME OF PARENT/GUARDIAN

Pediatric Therapy Associates, 2501 East Moore Avenue, Searcy, AR 72143

information pertaining to:

PATIENT NAME: _____
LAST FIRST MIDDLE

DOB: _____ SSN: _____ PHONE NUMBER: _____

INFORMATION TO BE RELEASED:
_____ Medical Evaluation and/or Medical Record
_____ Speech/OT/PT Evaluations
_____ Prescription for Therapy
_____ Treatment Plan

PURPOSE OF RELEASE:
_____ At Request of Parent/Guardian

This authorization will have an expiration date of: _____. I understand that I may revoke this authorization at any time by giving written notice to Pediatric Therapy Associates, except that a revocation of this authorization will not apply to any records already received in reliance upon the authorizations. A photocopy of this signed authorization shall constitute a valid authorization.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

_____ _____
SIGNATURE OF LEGAL REPRESENTATIVE, AUTHORITY OF LEGAL REPRESENT (SUCH AS PARENT/GUARDIAN) DATE