GOOD HANDS THERAPY INC.

MEDICAL RELEASE OF INFORMATION TO OR FROM GOOD HANDS THERAPY INC.

Date: _____

I, _____ hereby authorize one of all of the designated parties listed below to
(Parent, Guardian, Eligible Student)
request and receive the release of any protected health or academic information for payments or administrative operations or as it relates to treatment regarding _____ .
Child's Legal Name

I understand that I have the right to know at all times what information is shared regarding myself or my child. I understand that the identity of the designated parties must be verified before the release of my information. I know that I have the right to revoke this authorization at any time in writing.

Name: _____ Relationship: _____
Purpose: _____
Address to which information is sent: _____
Type of information released: _____

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Purpose: _____
Address to which information is sent: _____
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Name: _____ Relationship: _____
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Address to which information is sent: _____
Type of information released: _____

Records to be released:

- ☐ Medical records
- ☐ All academic records, including all IEP's
- ☐ Psychological records
- ☐ Behavioral records
- ☐ Other: _____

_____ _____ _____
Authorized Signature | Authorized Print Name | Relationship