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Richlands, NC 28574
Phone: (910) 430-2201
Fax: (910) 324-4325
Fax: (888) 653-7243
Email: prosteptherapy@gmail.com

RELEASE OF MEDICAL INFORMATION

Patient's Name:_______________________________________ Patient Date of Birth:_______________

I authorize Pro Step Therapy to disclose and/or receive my/my child's health records and/or insurance information to/from the third party recipients designated below. This includes evaluations, goals, medical records, treatment notes, and any other relevant information. In the event that I want an agency, organization, or individual to receive information, but not to release (or vice versa), I will so designate. Completion of this form is voluntary, and this authorization is in compliance with professional/client confidentiality and with the Health Insurance Portability and Accountability Act.

You will need to list your/your child's physician/pediatrician, Infant Toddler Program, school system, equipment company, and any other medical specialist you/your child sees. Also list any family members or any other persons whom you want medical information released to. Please use the back of this form if you need more space

Name of individual, organization or agency to release/receive information: Examples: Primary Care Physician/Pediatrician; CDSA/Infant Toddler Program, School System, DME & Prosthetics/Orthotics Co, Family Member, etc.)

Dr. / Facility Name and Location	**Contact Phone/Fax (if known)**
1)	1) Phone:
	Fax:
2)	2) Phone:
	Fax:
3)	3) Phone:
	Fax:
4)	4) Phone:
	Fax:
5)	5) Phone:
	Fax:
6)	6) Phone:
	Fax:

List any special instructions regarding this release of medical information:_________________________

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Signature of Patient/Parent/Guardian	Relationship to Patient	Date