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Richlands, NC 28574
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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. Please use the back of this form if you need more space.

Name of individual, organization or agency to release/receive information	**Phone/Fax Number or Address**
1) _____ Example:(Primary care physician/pediatrician)	1) Facility Name:_____ _____ _____
2) _____ Example:(CDSA/Infant Toddler Program)	2) _____ _____
3) _____ Example:(School System)	3) _____ _____
4) _____ Example:(DME & Prosthetics/Orthotics Co)	4) _____ _____
5) _____ Example:(Family Member)	5) _____ _____
6) _____	6) _____ _____

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

_____

_____

_____ _____ _____

Signature of Patient/Parent/Guardian Relationship to Patient Date