Authorization for Release of Medical Information/Records

Patient Name: _____ **Date of Birth:** _____/_____/_____

I hereby authorize Up & Movin' Pediatric Physical Therapy, PC to release photocopies of my medical records and/or health information to the following individual or organization:

Individual/Organization Name: _____

I further release Up & Movin' Pediatric Physical Therapy, Inc. from the responsibility of any effect the release of my clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretations of medical information contained therein and hold Up & Movin' Pediatric Physical Therapy, PC. Blameless for conclusions or opinions drawn without professional knowledge, assistance or review.

By state law, you must be advised that: The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus (HIV) also known as Acquired Immune Deficiency Syndrome (AIDS).

Patient Name: _____ **Parent/Guardian Name:** _____

Parent/Guardian Signature: _____ **Date:** _____

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