IT'S ABILITY
Pediatric Physical Therapy

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CONSENT FORM FOR RELEASE OF MEDICAL INFORMATION

While receiving therapy services it is often important to communicate information regarding diagnosis, plan of care and treatment outcomes with your child's primary care physician, specialist or other health care providers. The following statement grants consent for this communication.

I, _____, the undersigned, hereby authorize It's Ability, to release and provide copies of documents as are listed below to the individuals, agencies, institutions or organizations listed below.

I authorize It's Ability to contact the individuals, agencies, institutions or organizations listed below for the purpose of reciprocal sharing of information regarding diagnosis, plan of care, treatment outcomes or any other matter pertinent to the patient's physical therapy program.

I acknowledge and understand the purpose of this request and that my consent is hereby granted voluntarily. I understand that this release will expire when the patient is no longer a client of It's Ability. I further understand that I may cancel or revoke this authorization at any time in writing.

PATIENT'S NAME:_____
PATIENT'S DOB:_____
ADDRESS:_____

Requested Information or Documents:
( ) EVALUATIONS/NOTES/REPORTS
( ) DISCHARGE SUMMARIES
( ) OTHER (Please explain in detail):_____
_____

Information to be shared with: _____ _____

_____ _____

By my signature below, I consent to this release of pertinent medical information and documents listed above.
Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian:
_____Date:_____