# AUTHORIZATION TO OBTAIN/RELEASE PATIENT'S HEALTH INFORMATION

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

I, _____ (parent/guardian), authorize Dynamic Strides Therapy, Inc. to obtain/release all protected health information in any form (including oral, written and electronic).

☐ All records **OR** please check all that apply:

| | | |
|---|---|---|
| ☐ History/Physical | ☐ Progress Notes | ☐ Other (please specify): |
| ☐ Treatment Records | ☐ Radiology Reports | _____ |
| ☐ Medical Records | ☐ Operative Reports | _____ |

The purpose of this release is to_____(insert description).This authorization is effective from _____ (date) until _____ (date). I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider to which this authorization is directed. I understand this authorization is strictly voluntary and that the health care provider to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. This information, once it is released, may be re-disclosed by the recipient, and if re-disclosed, the information may no longer be protected by federal privacy laws. Any facsimile, copy or photocopy of the authorization authorizes release the records requested herein.

**Signature of Patient** _____ **Date** _____

**Signature of Patient's Guardian (if Patient is a minor)** _____

**Name of Patient's Guardian** _____**Date** _____

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