Consent for Release of Patient Information

_____

Patient Name Date of Birth

I hereby authorize Abilitations Children's Therapy & Wellness Center (ACTWC) to release information in my patient record to:

_____

_____

_____

Reason for Release:____**CONTINUITY OF CARE**_____

This request shall be valid for one year from date of signature, unless previously revoked or otherwise indicated (specify number of days or months):_____.

Other information:_____

I understand that by signing this form, that I hereby agree and authorize to the release of patient information to the above named person or organization. I have the right to revoke this authorization, in writing, at any time by sending such written notification to ACTWC office address. However, I understand that my revocation will not be effective to the extent that action based on this consent has been taken.

_____ _____

Patient/Parent/Legal Guardian Signature Date

_____ _____

Witness Date