Pediatric Therapy Center

10601 S. 72nd Street, Suite 103
Papillion, Nebraska 68046
402-932-2782
Fax 402-932-2705
www.ptcne.org

EMPOWERING CHILDREN, FAMILIES AND OUR COMMUNITY.

Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize and request the sharing of records between the following providers:

Provider 1: Pediatric Therapy Center
10601 S 72nd St
Papillion, NE 68046
402-932-2782 F - 402-932-2705

Provider 2: _____
Business Name

_____
Business Contact

_____
City, State

_____ _____
Phone Fax

Description of Information to be released: (check all that apply)
_____ Progress Notes _____ Entire Medical Record _____ Evaluation(s)
_____ Diagnostic Test Results _____ Discharge Summary _____ Clinical Notes
_____ Other_____

I understand the information released may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. A copy of this authorization may be utilized with the same effectiveness as an original. This authorization will expire by law 180 days from the date of this authorization unless otherwise specified below.

This authorization will be in effect until _____ (date or event).

I further understand that I may revoke this authorization at any time by notifying the Pediatric Therapy Center. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Caregiver Name: _____ Signature: _____ Date: _____