All For Kids Pediatric Therapy, LLC
8200 Homer Drive, Suite F
Anchorage, Alaska 99518
907-345-0050 907-344-5103 Fax

□ I hereby authorize, **All For Kids Pediatric Therapy, LLC** to request information **FROM**:

____
(Individual or Organization Name & Address)

□ I hereby authorize, **All For Kids Pediatric Therapy, LLC** to **RELEASE** information **TO**:

____
(Individual or Organization Name & Address)

Regarding the Following Patient:

Name: ______________________ Phone: __________

Address: ______________________ Date of Birth: __________

State: __________ Zip: __________ SSN#: __________

Records to be Released:

Date(s) treatment was received: ______________________

□ Consultation Report □ Entire Record □ History & Physical □ Evaluation □ Plan of Care

□ Photographs, Videos, & Digital Images □ Other: __________

□ Script for **Speech Therapy** Evaluation and/or Treatment

□ Script for **Occupational Therapy** Evaluation and/or Treatment

□ Script for **Physical Therapy** Evaluation and/or Treatment

I authorize the release of information relating to:

□Psychiatric Evaluation and/or Treatment □Alcohol/Drug Abuse Evaluation/Treatment

Purpose of Release:

□ Coordination of Care □ Insurance □ Litigation □ Personal □ Other: __________

This authorization expires on the following date, event, or condition: __________

(If I do not specify any expiration date, event, or condition, this authorization will expire in one year.)

Statement of Authorization:

- I understand that, except for research related treatment, All For Kids Pediatric Therapy, LLC will not condition my treatment upon my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to All for Kids Pediatric Therapy, LLC. A photocopy/fax of this authorization will be treated in the same manner as the original.
- I understand that once information is released as specified in this authorization, the facility, their employees and All For Kids Pediatric Therapy, LLC, cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

______________________________ ______________
Signature of Patient/Legal Authorized Representative Date

______________________________ ______________
Relationship to Patient Reason Patient Unable to Sign

______________________________ ______________
Signature of Witness Date

--***For Office Use Only***--

Medical Records Released By: __________________ *Date:* __________

Medical Records Released To: __________________ *Date:* __________

Method: □ *Mailed* □ *Picked up* □ *Faxed #* __________