2 Pillsbury Street, Suite 404
Concord, NH 03301
Phone: (603) 228-STAR (7827)
Fax: (603) 228- 7828
www.swingforthestars.com

Authorization for Release & Exchange of Personal Health Information

Patient's Name: ____________________________ **DOB:** ____________ **Date of Request:** ______________
Physical Address: ____
Person Requesting Release: _______________________________ **Relationship:** ______________________
Primary Phone: ___________________________ **Other Phone:** _____________________________

Type of Protected Health Information Requested:
____
____

Purpose of Disclosure: Ongoing care and treatment at Swing for the Stars Pediatric Therapy Center

Please read the following statements carefully and check only if applicable:

____ I give permission for the release of my child's medical records FROM Swing for the Stars,
TO : ____

____ I give permission for the release of my child's medical records FROM ____________________________,
TO: Swing for the Stars Pediatric Therapy Center.

____ I give permission for telephone contact between Swing for the Stars and ___________________________

____ I give permission for e-mail communication between Swing for the Stars and _______________________

Expiration: This authorization will expire on _____________. *If no date is specified, this authorization shall expire 12 months from the date it was signed.*

Revocation: I understand that I may revoke this authorization at any time, by notifying Swing for the Stars Pediatric Therapy Center in writing, except to the extent that any actions initiated in reliance on the authorization may have been completed prior to my revocation.

____ ____________
Signature of Parent/Guardian **Date**

____
Printed Name of Parent/Guardian

****A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL****