OCCUPATIONAL THERAPY SERVICES

9810 F.M. 1960 Bypass, Suite 190

Humble, TX 77338

Phone: 281-446-0371

Fax: 281-446-4299

Clinical Records Release Form

This gives permission for release of information from OTS to you or your provider.

DATE: _____ Medicaid :_____

Patient Name: _____Date of Birth_____

Address:_____

City/State/Zip: _____

Phone: _____Cell:_____

I authorize the center to release the following information:

Information to be released: Evaluation Report and Updates

Release to: _____

Address:_____

City/State/Zip:_____

Phone:_____ Fax:_____

1. I understand that this authorization shall be valid through ___/___/___, but that I may revoke it in writing at any time: any such revocation shall have no effect on disclosures made previously.
2. I understand that I have the right to inspect and copy the information released.
3. I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or provide the most appropriate care for me.
4. I understand that the release of information may not be re-released to any person or organization without my written consent.

Parent or Guardian: _____ Date: _____

Witness by: _____ Date: _____