OCCUPATIONAL THERAPY SERVICES

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Humble, TX 77338

Phone: 281-446-0371
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Clinical Records Request Form

This gives permission for OTS to request information from another provider.

Date:_____ Medicaid #_____

Patient Name:_____ Date of Birth:_____
Address: _____
City/State/Zip:_____
Phone:_____Cell:_____

I authorize the center to request the following information: clinical progress notes/reports as applicable to patient referral.

Information Requested: Medical Records pertaining to therapy

Request from: _____
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: _____ Date: _____