



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ Date of Birth _____
Address _____
Phone Home _____ Cell _____
Parent/Guardian _____

Provider: Minnetonka Pediatric Therapy Center
(Who is or
Releasing _____
Information) _____

Requestor: Minnetonka Pediatric Therapy Center
(Where you or
Want information _____
Sent) _____

Information Medical office notes
Requested: Treatment summary/history
 Educational testing results/reports
 Other – Please specify date(s) of service

Purpose of Insurance change/transfer
Release: Mutual exchange of information
 Transfer out of clinic
 Referral/consultation
 Other _____

Time I understand that this consent is valid for one year. It can be
Limit: revoked at any time prior to one year if requested in writing.

Parent/Guardian Signature _____
Date