AUTHORIZATION FOR RELEASE OF INFORMATION

HANDPRINTS & FOOTSTEPS
5930 Vandervoort Dr Ste A
Lincoln NE 68516

Healthcare information may be used or disclosed to carry out treatment, payment, or health care operations.

I. Regarding the records of _____
(Child's Name)
Birth date _____/_____/_____

II. Person/Agency Release

I give permission to _____ to
(Name of Agency; example: Dr. _____, name of school or hospital, etc.)
release information to Handprints and Footsteps about the above named child.

Purpose of request: information for assessment and/or therapy

The specific records which are being requested are :

Health Record	Prenatal/Birth History
Diagnostic Information	Therapy Information (OT/PT/Speech)
Medical History	

III. Handprints and Footsteps Release

I give permission to Handprints and Footsteps to release information to

_____
(Name of Agency; example: Dr. _____, name of school or hospital, etc.)
about the above named child.

Purpose of request: information for assessment and/or therapy

This authorization will remain in effect until discharge from therapy or you may revoke this authorization at any time by giving us written notice.

IV. _____
Signature of parent/guardian

_____
Address City State Zip

_____
Phone

_____
Date