373 Blair Park Road, Suite 204, Williston, VT 05495
(P) 802-662-4672 (F) 802-662-5964
www.kidsrehabgym.org

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

Patient Name:_____
Address: _____
_____
Date of Birth: _____

This will authorize **The KidsRehabGYM INC.** to ❑ **obtain** ❑ **release** a copy of my records regarding my medical diagnosis, treatment, and condition including, but not limited to, the following: *(check all that apply)*

❑ **Any / all deemed appropriate records**

❑ Records only for specific diagnosis(es) *(specify diagnosis(es):*_____

❑ Physician office records *(specify office(s):*_____

❑ Hospital records *(specify hospital):* _____

❑ School district, teacher, and therapist information *(specify):*

_____

❑ Other *(specify)*:

_____

_____

- ✓ I understand that all records obtained will observe all HIPAA confidentiality guidelines.
- ✓ I also understand that I have the right to inspect and request a copy of information to be disclosed and that I may withdraw this authorization at any time, except to the extent that action has been taken on this authorization.
- ✓ I understand that this authorization shall expire, without my express revocation, one year from the date written below.
- ✓ I understand there may be a fee involved for the reproduction costs of these records.

❑ Please mail records to: **The KidsRehabGYM Inc.**
373 Blair Park Road, Suite 204
Williston VT 05495
Phone: 802-662-4672

or FAX TO: 802-662-5964

_____ _____

Date ***Signature of the patient****, patient's legal guardian, or the patient's personal representative if the patient is deceased*

Witness:_____

Name *(please print)*:_____