ProActive
PEDIATRIC THERAPY

CHILD'S NAME: _____

DATE OF BIRTH: _____

RELEASE OF INFORMATION

I hereby authorize the exchange of Protected Health Information between PROACTIVE PEDIATRIC THERAPY, LLC, and the specified individuals/agency listed below. This authorization allows the person/agency (allows information exchange with anyone representing that agency) below to use or disclose, request, and/or exchange my protected health information as indicated below to ProActive Pediatric Therapy, LLC.

PRIMARY DOCTOR/CLINIC:_____ **PHONE #:** _____

SPECIALTY DOCTOR(s)/CLINIC: _____ **PHONE #:** _____

_____ **PHONE #:** _____

PRESCHOOL/SCHOOL DISTRICT: _____**PHONE #:** _____

OTHER:

_____**PHONE#:**_____

Send or Share by: ☐ **Mail** ☐ **Fax** ☐ **Secure Email** ☐ **Phone**

SIGNATURE: X _____ **DATE:** _____

(Parent/Legal Guardian)

Information to be released/exchanged, check all that apply:

☐**Medical Records: including evaluations, history & physical, diagnosis codes, progress notes, consultations, medications (previous and current), lab and s-ray reports, MRI results, CT scan results, surgical reports, radiology reports**

☐**Physical Therapy: including evaluations, treatment plans & therapy notes**

☐**Speech Therapy: including evaluations, treatment plans & therapy notes**

☐**Occupational Therapy: including evaluations, treatment plans, & therapy notes**

☐**School Records: including IFSP, IEP, progress notes, behavior notes, educational testing**

☐**Other and/or specific people within an agency such as a teacher:**

☐**Other**
(specifics)_____

_____

Please turn over →

Terms: This release will last for 12 months from date of signature or upon discharge of Therapy services.

Purpose: ProActive Pediatric Therapy, LLC will exchange/release information for purposes of evaluation, treatment, case coordination, caregiver training, and follow-up care and for payment via phone, fax, and/or email.

I have read the above and authorize the request or disclosure of Protected Heath Information. I understand I may revoke this right at any time by providing verbal or written notice toProActive Pediatric Therapy, LLC except to the extent that action has been taken in reliance and on the authorization or as otherwise stated in ProActive Pediatric Therapy, LLC's Notice of Privacy Practices.

SIGNATURE: X _____ DATE: _____
(Parent/Legal Guardian)

PHOTO RELEASE

I, _____ hereby agree and consent as follows:

A. **I consent and authorize ProActive Pediatric Therapy, LLC located at 1717 Boyson Rd Hiawatha, IA 52233 to use my likeness in any photograph, video or other digital media ("photos") in any and all of its publications, including print or web-based publications.**
B. **I irrevocably authorize ProActive Pediatric Therapy, LLC to copy, edit, enhance, crop, or otherwise alter any Photo for use in their publications. I also waive any rights for approval or inspection of Photos.**
C. **I understand and agree that all Photos are the property of ProActive Pediatric Therapy, LLC and will not be returned to me.**
D. **I acknowledge that I am not entitled to any compensation or royalties with respect to the use of the Photos.**
E. **I agree to release and forever discharge ProActive Pediatric Therapy, LLC and its affiliates, successors, officers, employees, representatives, partners, agents and anyone claming through them, in their individual and /or corporate capacities from any and all claims, liabilities, obligations, promises, agreements, disputes, demands, damages, causes of action of any nature of kink, known or unknown, which I, and anyone claiming on behalf of me, may have or claim to have against Releasee in connection with this Release.**
F. **I have carefully read and fully understand all the provisions of this Photo Release Form and am freely, knowingly, and voluntarily signing.**

SIGNATURE: X _____ DATE: _____
(Parent/Legal Guardian)