mptc
learn. play live.

Authorization for Release of Medical Information

Patient Name: _____ DOB: _____

I (parent/guardian), _____ hereby authorize Minnetonka Pediatric Therapy Center and its providers to share health and other medical records, reports, evaluations, or other relevant health information for my child, _____ to the providers listed below. This may also include educational evaluations, reports, IEPs, etc. I understand that this consent is valid for **one year** and that it can be revoked at any time prior to one year if requested in writing. The information listed on this form is for sharing OR obtaining information.

LIST ALL HEALTH RELATED SERVICES (physician, teacher, dietician, dentist, etc):

Site and Provider name	Provider Title	Phone Number	Fax Number

_____ _____

Parent/guardian signature **Date**