Home Therapy Resources Inc

CONSENT FOR RELEASE OF MEDICAL RECORDS

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTHCARE INFORMATION BOTH TO/FROM HOME THERAPY RESOURCES, INC.

Patient Name: _____ **Date of Birth:** _____

I hereby authorize ***Home Therapy Resources, Inc.,*** to release my medical records to include but not limited to patient evaluation, testing scores, progress notes to the following individual(s) or organization(s) listed below:

Name: _____

Address: _____

Phone: _____ Fax: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

For Home Therapy Resources, Inc. to receive medical information:
I hereby authorize the individual(s) or organization(s) listed above to release medical information from the patient's medical charts. The information will be used for Occupational, Physical and Speech Therapy assessment, evaluations and treatments only. Please send information to:
Home Therapy Resources, Inc.
6715 East 41st Street
Tulsa, OK 74145 Phone: 918-806-0106 Fax: 918-806-0113

I do understand that this consent may be revoked at any time by written request submitted to Home Therapy Resources, Inc.

Parent/Guardian Signature: _____ **Date:** _____
Relationship to Patient: _____