# Skagit OT Studio

Medical Information Release Form

Client Name:_____ Date of Birth:_____

Address:_____

I am aware that information from the client's medical records is confidential and protected by Federal and State laws, which prohibits disclosure of these records without my specific consent or otherwise permitted by regulations. I certify that I am the parent or legal guardian for the above named child and that I have the authority to sign this exchange of information.

The care providers listed below have my permission to exchange medical information about the client. My signature authorizes the mutual exchange of medical information regarding the above named child between Margaret Kotal, MS, OTR/L at Skagit OT Studio, 11252 Walker Rd, Mount Vernon, WA 98273, 360-757-8784 and:

| Name | Address |
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This Medical Information Release may be revoked by the legal guardian at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Skagit OT Studio. I understand that the revocation will not apply to information that has already been released in response to authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. A copy or fax of this document shall be considered valid in lieu of originals.

_____ _____

Signature of Parent or Legal Guardian Relationship to Client

_____ _____

Printed Name of Parent or Guardian Date