Soulshine Pediatric Therapy LLC
Johns Island, SC, Phone: 843-730-1552, Fax: 843-429-6740

Permission to Request and Release Information

By signing this form, I authorize Soulshine Pediatric Therapy to request information about me relevant to direct treatment and continued care. Information may be requested from any physician, physician's office, therapist, hospital, home health agency, LEA/school, daycare, BabyNet, child service coordinator, or early interventionist.
I also authorize Soulshine Pediatric Therapy to release current clinical information (including evaluations and treatment notes) that they obtain regarding myself to my physician, the CDSA, other therapists involved in my care, LEA/school, daycare, hospital, home health care agency, or other such institution(s) needing information for continuity of care.

I also authorize Soulshine Pediatric Therapy to release clinical and billing information, including any information regarding my diagnosis and treatment for the purpose of determining eligibility for insurance, processing insurance claims, or assessing quality, cost, and appropriateness of care

THIS AUTHORIZATION SHALL EXPIRE ONE YEAR FROM THE DATE OF SIGNATURE.

Patient's Name: _____ **Relation to Patient:** _____

Signature: _____ **Date:** _____