Pediatric Learning Center, Inc.
Therapy, Education, & Support
Ph: (901) 290-8558 Fax: (901) 231-1112 Web: www.plcmemphis.org

# RELEASE OF INFORMATION

| CHILD'S NAME: | DATE OF BIRTH: |
|---|---|
| ADDRESS: | |
| PARENT / GUARDIAN: | |

I authorize the Pediatric Learning Center to obtain and release all of this patient's medical records, case records, case histories, and/or educational files to and from:

☑ Covered Entity: _____

Physician: _____

Phone Number: _____Fax Number: _____

☑ I authorize the Covered Entity listed above to disclose requested health information to the Pediatric Learning Center. Phone: (901) 290-8558. Fax: (901) 231-1112. Email: info@plcmemphis.org.

I understand that these records are being released and/or obtained for use for the purpose of continuity of care, financial reimbursement, and case management from and to all past or current providers of educational and medical care.

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|---|---|---|
| ☑ Continuity of Care | ☐ Request of Patient | ☐ IFSP / IEP Plan |
| ☐ Medical History | ☐ Payment for Services | ☐ Immunization Records |
| ☐ Request of Patient | ☐ Nutritional Care | ☐ Swallow Study Results |

Unless otherwise permitted by law, further release of this information is prohibited without my prior written consent. I fully understand this authorization, and my consent has been made voluntarily. I understand this release remains current and valid while under the care of the Pediatric Learning Center. I have read the Pediatric Learning Center HIPAA policy and understand and agree that a photocopy or facsimile of this executed authorization is as valid as the original. The Pediatric Learning Center has permission to release and obtain information from the entity listed above.

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| Parent / Guardian Signature: |
| Printed Name of Parent / Guardian: |
| Date: |

*Updated: December 8, 2022*