UAMS | Schmieding Developmental Center

AUTHORIZATION FOR ACCESS TO & RELEASE OF INFORMATION

I, _____, hereby authorize Schmieding Developmental Center to release/request medical records, to include verbal communication, from the following individuals/clinics/hospitals:

PCP: _____ Phone: _____

ENT: _____ Phone: _____

Vision: _____ Phone: _____

Neurology: _____ Phone: _____

Genetics: _____ Phone: _____

Birth Hospital: _____ Phone: _____

Mental Health: _____ Phone: _____

ST, OT, PT: _____ Phone: _____

Other: _____ Phone: _____

Please list persons that may receive information (verbal or written) on behalf of your child.

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Information of:

Patient Name: _____ DOB: _____

The purpose of this authorization is for: _____ Payment _____ Treatment _____ Other: _____

The purpose of this disclosure is for evaluating &/or treatment. I understand that this authorization may be revoked at any time by given written notice to the facility. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this authorization shall constitute a valid authorization. This authorization will expire _____ (date) OR 1 year from date signed.

The facility, its employees, and clinicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations. I agree to pay the cost of copying, supplies, labor, postage, and other expenses associated with the request as allowed by law.

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your signing this authorization.

_____ _____ _____

Legal Representative Signature Relationship Date

519 Latham Dr.
Lowell, AR 72745
(479)750-0125, Fax (479)750-0323

UAMS | Schmieding Developmental Center

AUTHORIZATION FOR ACCESS TO & RELEASE OF INFORMATION

I, _____, hereby authorize Schmieding Developmental Center to release/request information from:

School District/Name: _____

Address: _____ _____
Street Address *City* *State* *Zip*

Phone: _____ Fax: _____

Information of:
Patient Name:_____ DOB: _____

The purpose of this authorization is for: _____ Payment _____ Treatment _____ Other: _____

Information to include:

- ☐ School Report
- ☐ Reports Card History
- ☐ Language Proficiency Testing
- ☐ Developmental/Psycho Ed Evaluation
- ☐ 504 Plan
- ☐ Behavior Evaluation/Plan
- ☐ Physical Therapy Evaluation
- ☐ Verbal Communication
- ☐ All Records
- ☐ Teacher Rating Form
- ☐ Achievement Test (Benchmark)
- ☐ MAC &/or ELDA Scores
- ☐ IFSP/IPP/IEP
- ☐ RTI / IRI Plan
- ☐ Speech Evaluation
- ☐ Occupational Therapy Evaluation
- ☐ Health Plan
- ☐ Other: _____

I understand that this authorization may be revoked at any time by given written notice to the facility. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this authorization shall constitute a valid authorization. This authorization will expire _____ (date) OR 1 year from date signed.

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