

# Focus Therapy Services, Inc.

P.O. Box 12192, New Bern, NC 28561  
Main Office: 252-672-8676, Bayboro Office: 252-745-5500  
Fax: 252-672-8677, [www.focustherapy.org](http://www.focustherapy.org)

## **Authorization for Disclosure of Health Information**

I hereby authorize (provider name/address)  
Focus Therapy Services, Inc.  
3310 Neuse Blvd, Suite A  
New Bern, NC 28560

To Consult with (care provider name/address)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_

\_\_\_\_\_  
Date of Birth  
\_\_\_\_\_  
Telephone: (     )  
\_\_\_\_\_

Medical record release request for dates covering: (from) \_\_\_\_\_ (to) \_\_\_\_\_  
Parent/guardian understands by signing this document that they are enabling the providers listed above to discuss and disclose information pertaining to my treatment. Parent/guardian understands that this will include information relating to (check if applicable below):

- \_\_\_\_\_ Medical care and treatment
- \_\_\_\_\_ Education/academic planning and service records
- \_\_\_\_\_ Behavioral health service/ psychiatric care
- \_\_\_\_\_ Treatment for alcohol and/or drug abuse
- \_\_\_\_\_ Developmental history/evaluation and treatment
- \_\_\_\_\_ Occupational, physical or speech therapy evaluations and treatment plans
- \_\_\_\_\_ Other \_\_\_\_\_

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the day, event or condition (one year from date signed). The facility, its employees and officers are hereby released from any legal responsibility or liability for disclosure of the above information the extent indicated and authorized herein.

### **Signed:**

\_\_\_\_\_  
(patient or patient's guardian) (date)

\_\_\_\_\_  
or (legal representative) (relationship to patient) (date)

\_\_\_\_\_  
(signature of witness ) (date)