Medical Records Release

RightStart Therapy Services, Inc.
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Please allow up to five business days to complete your request.

Patient Name: ______________________________________**DOB:** ____________________________

I, ____, give RightStart Therapy Services permission to release my child's protected health records to:

Please write the name of person/facility whom records will be going to (check all that apply)

- ☐ Parent/ Self: ____
- ☐ Doctors Office: ____
- ☐ School: ____
- ☐ Other (please specify): ____

Please indicate what records you are requesting and dates needed (check all boxes that apply):

- ☐ Evaluations From: ________________ To: _______________
- ☐ Therapy progress notes From: ________________ To: _______________
- ☐ ALL

All records will now be emailed, as we are now a paperless and electronic Medical Records office.

- ☐ E-Mailed (list e-mail): ____

*I give RightStart Therapy Services permission to send my child's medical records through an unsecured e-mail to the above listed e-mail address.

Parent/Guardian Print Name: ____

Parent/Guardian Signature:___________________________________ Date: _______________________

Relationship to patient:_____________________ Best contact number:______________________________

Thank you for your patience.

Completed By: ___________________
Date:___________________