Phone: 870-919-0274
Fax: 870-277-4335

Authorization for Release of Confidential Information

To / From Jumping Jelly Beans
906 E Matthews
Jonesboro, AR 72401

To / From _____
_____
_____
_____

I, _____, the patient or parent/guardian of the patient named below, give Jumping Jelly Beans Pediatric Therapy Clinic permission to obtain from or give to the above named agency/person pertinent, social, medical, or other information as listed below. I understand that this information is confidential and will only be used for the benefit of this patient. I understand that this information may be subject to re-release by the recipient without the knowledge or consent of Jumping Jelly Beans and that Jumping Jelly Beans is in no way responsible for this action. I further understand that this consent form is considered valid for ONE YEAR or for the duration of this patient's treatment, whichever is shortest, and that I may revoke this release at any time by requesting this in writing and submitting it to this office.

Notice: Jumping Jelly Beans may not condition services upon signing this form unless the services are being provided for a third party.

Documents to be released:

1. _____
2. _____
3. _____

Purpose for release:

At the request of the patient or parent/guardian

_____

Patient's Name: _____ DOB: _____

Signature of Patient or Parent/Guardian_____ Date:_____