MEYER CENTER FOR SPECIAL CHILDREN
1132 RUTHERFORD ROAD
GREENVILLE, SOUTH CAROLINA 29609

PARENTAL AUTHORIZATION FOR RELEASE OF INFORMATION

Parents, Complete Only this Portion of the Form. We will send to physician.

I hereby give my permission for the release of medical information concerning my child to the Meyer Center for Special Children. I understand that this authorization is voluntary, and that I may revoke this authorization at any time by notifying the Meyer Center for Special Children in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by the Center before receiving my revocation.

Child's Name _____

Parent/Guardian Signature _____ Date _____

Primary Physician_____

Name of Medical Practice_____

Address _____

Phone_____

PHYSICIAN REFERRAL & LETTER OF MEDICAL NECESSITY

Child's Name:_____ DOB: _____

Diagnosis: _____

ICD-9 Code(s):_____

This will serve as a Letter of Medical Necessity and referral for the above-referenced patient to receive:

- ☐ *Physical Therapy* *(1-3 times per week, 30-60 minutes)*
- ☐ *Occupational Therapy* *(1-3 times per week, 30-60 minutes)*
- ☐ *Speech Therapy* *(1-3 times per week, 30-60 minutes)*

Dates of Service: From August 2012

To August 2013

These services are to be provided by registered therapists at the Meyer Center for Special Children. It is understood that this letter must be renewed annually.

Physician's Signature:_____

Physician's Printed Name:_____

Name of Practice:_____

Address:_____

Phone:_____ **Fax:**_____