

125 E. Bethpage Road, Suite 5 Plainview, NY 11803

516-731-5588 516-577-9049 fax

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www.mksallc.com



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**HASC Executive Offices: 5902 14th Avenue, Brooklyn, NY 11219 • Tel. 718-686-5900 • Fax 718-853-0213**

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**MKSA**

**PHYSICAL/ PRESCRIPTION RELEASE FORM**

 **DATE: \_\_\_\_\_\_\_\_\_\_\_**

**NAME OF CHILD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.:\_\_\_\_\_\_\_\_\_\_\_\_**

To provide the approved services to the child named above, MKSA LLC must have copies of the child’s current annual physical exam and immunization records, and, when appropriate, prescriptions for physical, speech and/or occupational therapies.

Please forward these records to us as soon as possible.

If you would like **us** to obtain the records directly from your pediatrician, please complete the following, sign the consent portion and return this form to our office.

**DOCTOR’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Phone/ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I give permission for my child’s physician to release the *current* annual physical exam and immunization records, and if applicable, prescriptions for physical, speech and/or occupational therapies to MKSA LLC.

**PARENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**