



"Helping children live functional and independent lives"

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Reliantpediatrictherapy.com

**RE: Authorization Release Request**

Patient Name: \_\_\_\_\_

Patient insurance ID: \_\_\_\_\_

Discharge date: \_\_\_\_\_

Therapy services: \_\_\_\_\_

To Whom It May Concern,

This is to inform you that my child's therapy service provider has changed from \_\_\_\_\_ to *RELIANT PEDIATRIC THERAPY SERVICES*. To ensure continuation of therapy services, I hereby request that you release any prior authorization and issue a new one to *RELIANT PEDIATRIC THERAPY SERVICES*. Thank you for your prompt attention to this request.

\_\_\_\_\_

Parent/Legal Guardian Signature