Growing Together in Mind and Body

# CONSENT FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone #: _____

Address: _____ Cell #: _____

City/State/Zip: _____

Primary Care Physician Name and #: _____

I authorize The Therapy Tree, LLC to release and/or obtain information to/and/or from:

_____ _____

_____ _____

_____ _____

Specific information/reports requested:

___ Developmental Reports ___ OT/PT Reports ___ Vision Evaluation Reports

___ Speech/Language Reports ___ Audiological Reports ___ IFSP/IEP

___ Medical Reports ___ Other: _____

The information is needed for the following purpose(s):

___ IFSP/IEP Development/Planning ___ Treatment Planning ___ Team Collaboration

___ Other: _____

The consent is valid until discharge of service or upon written revocation of parent/legal guardian, or minor age 12-17, whichever date is sooner.

_____ _____ _____

Printed Name of Client/Parent/Guardian Client/Parent/Guardian Signature Date

Counseling-Minors 12-17 years old:

_____ _____ _____

Printed Name of Client Client Signature Date