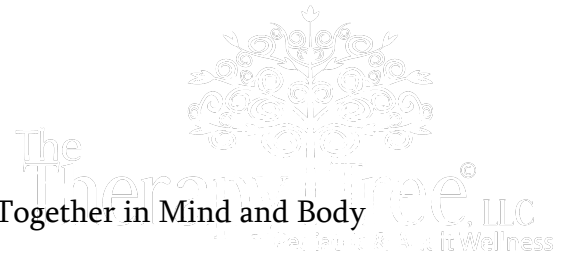




Growing Together in Mind and Body



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:

<input type="checkbox"/> Developmental Reports	<input type="checkbox"/> OT/PT Reports	<input type="checkbox"/> Vision Evaluation Reports
<input type="checkbox"/> Speech/Language Reports	<input type="checkbox"/> Audiological Reports	<input type="checkbox"/> IFSP/IEP
<input type="checkbox"/> Medical Reports	<input type="checkbox"/> 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

