



Consent for Release of Information

Child's Name: _____ Date of Birth: _____

My signature below will constitute my consent for the release and exchange of pertinent educational, medical / audiological, and psychological records relative to my child between *Maureen Barton's Occupational Therapy Service at Coastside Pediatric Therapy Center* **and**

Name of Organization / Individual: _____

Address: _____

Phone Number: _____

I understand that the records released will be kept confidential by the receiving person or agency and used for professional purposes disclosed to me.

I further understand that as parent or legal guardian I have the right to review my child's records and to withhold any records which I do not wish to be forwarded to the above person or agency.

Signature of Parent / Guardian: _____ Date: _____

Printed Name of Parent / Guardian: _____ Date: _____

Address: _____

Phone Number: _____

