ADVANCE THERAPY
occupational, physical and speech therapy for children

CONSENT TO RELEASE INFORMATION

I authorize Advance Therapy staff to share information regarding my child with the following people/organizations: (school, social worker, ABA therapist, PCA, etc.)

Name and/or Organization Phone and/or FAX

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Information to be exchanged includes records, reports, general collaboration, and recommendations.

This information may be exchanged via phone, written documents, mail, fax, and email (no personally identifying information).

Information exchanged will be used solely for the purpose of evaluation and treatment planning for:

Child's Name Birthdate

I understand that my records are protected and cannot be disclosed without my consent. I may revoke this authorization at any time.

Parent/Guardian Signature Date