Dogwood Pediatric Therapy

6428 Cape Charles Dr. Raleigh, NC 27617 Ph: 919-247-4551 Fax: 919-882-9569

CONSENT FOR RELEASE OF PATIENT INFORMATION

I hereby authorize Dogwood Pediatric Therapy to release information in my child’s record, including evaluation results, goals, or progress notes to:

* My child’s pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* My child’s school / preschool: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* The CDSA
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of any exchange will be to coordinate patient care.

I understand that this consent is voluntary and that I may revoke this consent in writing at any time.

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Patient Name Date of Birth

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Parent / Guardian Name Date