STONES WORTH STEPPING, P.C.

PEDIATRIC PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY

AUTHORIZATION FOR RELEASE OF INFORMATION

Child's Name:_____

I, as the parent or guardian, request and authorize Stones Worth Stepping, P.C. to release/obtain information with the following:

_____ Phone/email_____

_____Phone/email_____

_____Phone/email_____

for the following purpose(s):

Consent	Deny	Type of Information to be released
		Medical Records: Occupational/Speech Therapy Evaluation/Progress Notes
		Phone/email consult with the educational/professional team members
		Exchange of patient information regarding treatment planning

Please specify the reason for the release_____

_____

Please check one of the following:

	This authorization shall be deemed to permit the continuing release of the designated information until such time as this authorization shall have been revoked by me (us) in writing.
	This authorization shall not be deemed to permit the continuing release of the designated information.

_____

Signature of Parent/Guardian

_____

Date