the Center for Pediatric Therapy, inc.
9 Bristol Court Wyomissing, Pa. 19610
PH (610) 670-8600 FAX (610) 670-9104
www.cptherapy.com

CONSENT TO RELEASE or REQUEST CONFIDENTIAL INFORMATION

PROFESSIONAL RELEASE of INFORMATION

I authorize a release / request of confidential information (pertinent medical / therapy / educational records or information) regarding my child, ___________________________ between the Center for Pediatric Therapy, inc. and the following physician / agency / school:

Name ____
Address ____
Phone # ______________________________

Name ____
Address ____
Phone # ______________________________

Name ____
Address ____
Phone # ______________________________

I authorize **telephone contact** with the above to discuss my child's evaluation/progress for purpose of continuity of care. **YES** □ **NO** □

Parent/Guardian Signature: **Date:**

EVALUATION REPORT

You may share the report with anyone of your choice. At your request, a copy of your child's **Evaluation Report** will be sent to one physician or agency of your choice. **Please mail to:**

Physician/Agency ____

Address ____

Parent/Guardian Signature: **Date:**

OTHER CAREGIVERS RELEASE OF INFORMATION

I authorize my child's therapist to discuss relevant therapy information with the following individuals that may bring my child to therapy.

Name ____________________________________ Relationship ___________________
Name ____________________________________ Relationship ___________________

Parent/Guardian Signature: **Date:**