Children's Therapy Center

Helping children achieve their fullest potential

PARENT/GUARDIAN PERMISSION TO RELEASE CONFIDENTIAL INFORMAITON

I authorize **CHILDREN'S THERAPY CENTER** to obtain, receive, or exchange information about my child, _____ (name of patient), whose birth date is_____.

In granting such permission, I understand that such information will remain confidential to all other parties not directly related to the care and development of the above named child. Such information will only be used to give the child the best available professional help.

Type of information allowed to be requested, obtained, or exchanged includes:

___ Medical History/Reports
___ Psychological Reports
___ Special Education Reports
___ Therapy Reports (specify) _____
___ Verbal/Telephone Consultation
___ Other (specify) _____

I release **CHILDREN'S THERAPY CENTER** and its staff from any legal liability for disclosing or acquiring information which I have permitted by signing this form.

I also release any person, organization, or agency from any legal liability for giving or obtaining information to/from **CHILDREN'S THERAPY CENTER**.

This authorization is valid for one year from the date of my signature.

_____

Signature of Parent/Guardian Date