A to Z
Pediatric Therapy

2021 RELEASE OF CONFIDENTIAL INFORMATION

Child's Name: _____

Date of Birth: _____

I hereby authorize a release of information (i.e. medical records, e valuations, recommendations) from the individual(s) indicated below, concerning the above-named child.

_____Initial

I hereby authorize A to Z Pediatric Therapy, LLC to contact the individual(s) indicated below by phone, email, or fax, concerning the above-named child.

_____Initial

Authorization for release of medical records such as those listed above expires one year from the date of signature. I understand that gr anting consent f or release of these records is voluntary. Consent can be revoked at any time.

_____ _____

Parent/Guardian Signature Date

Releasing physician/clinic/professional information:

1. Name:_____
   Name of Practice/School: _____
   Profession/Discipline: _____
   Phone:_____ Email: _____

2. Name:_____
   Name of Practice/School: _____
   Profession/Discipline: _____
   Phone:_____ Email: _____

3. Name: _____

Name of Practice/School: _____

Profession/Discipline: _____

Phone:_____ Email: _____

4. Name: _____

Name of Practice/School: _____

Profession/Discipline: _____

Phone:_____ Email: _____

5. Name: _____

Name of Practice/School: _____

Profession/Discipline: _____

Phone:_____ Email: _____