‘ more than words’ Pediatric Therapy

RECORDS RELEASE

NAME_____NICKNAME_____

PLEASE CHECK ONE: MALE_____FEMALE_____DOB:_____

PT SS#_____

ADDRESS_____CITY_____ST_____ZIP_____

HOME PHONE#_____CELL#_____OTHERPH#_____

MOTHER’S NAME_____FATHER’S NAME_____

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION FROM THE MEDICAL RECORDS OF MY CHILD.

I AUTHORIZE QUALIFIED PROFESSIONALS TO DISCUSS AND COLLABORATE USING MY CHILDS THERAPY NOTES AND DATA.

INFORMATION RELEASED TO NAME “more than words’ PEDIATRIC THERAPY ASSOC. INC.

ADDRESS 1701 N. PATTERSON ST. VALDOSTA GA. 31602

PHONE_229-244-4545 FAX# 229-244-4244

CHECK ONE PICK UP_____FAX_____ MAIL_____

SIGNATURE OF PARENT OR GUARDIAN_____DATE:_____

OFFICE PHONE : 229-244-4545 FAX : 229-244-4244 EMAIL marlana.mtwpeds@gmail.com