Children's Therapies, Inc.

I, _____, _____ of _____
(parent/guardian) (relationship to child) (child's name)
authorize the release of his/her medical information to or from the following:

Please include your Pediatrician or Primary Care Physician, any other professionals that may require information, for example, a Specialist, Early Steps, your child's school and family/friends that bring your child to therapy so that we may speak to them about the session.

1._____ 8._____

2._____ 9._____

3._____ 10._____

4._____ 11._____

5._____ 12._____

6._____ 13._____

7._____ 14._____

X_____ _____
Signature of parent/guardian Date

My Signature on a facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.