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## Authorization to Exchange, Obtain or Release Information

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

For the reasons identified in this form, I \_\_\_\_\_ (Parent, Guardian/  
Legal Representative) hereby grant OT4LIFE permission to communicate (exchange, obtain,  
and/or release) my child's medical information for the purpose of coordinating care with other  
professionals, providing continuity of services, and updating therapeutic progress with the  
following individual(s) and/or organization(s):

1. Individual/Organization Name: \_\_\_\_\_

Individual/Organization Contact Information: \_\_\_\_\_

2. Individual/Organization Name: \_\_\_\_\_

Individual/Organization Contact Information: \_\_\_\_\_

3. Individual/Organization Name: \_\_\_\_\_

Individual/Organization Contact Information: \_\_\_\_\_

4. Individual/Organization Name: \_\_\_\_\_

Individual/Organization Contact Information: \_\_\_\_\_

5. Individual/Organization Name: \_\_\_\_\_

Individual/Organization Contact Information: \_\_\_\_\_

6. Individual/Organization Name: \_\_\_\_\_

Individual/Organization Contact Information: \_\_\_\_\_

7. Individual/Organization Name: \_\_\_\_\_

Individual/Organization Contact Information: \_\_\_\_\_

8. Individual/Organization Name: \_\_\_\_\_

Individual/Organization Contact Information: \_\_\_\_\_

**Information to Be Released (Please check all that apply):**

Medical History

Therapy Evaluation/Re-Evaluation/Plan of Care

OT  SLP  PT  Other: \_\_\_\_\_

Treatment Notes

OT  SLP  PT  Other: \_\_\_\_\_

School Records (Evaluations, IEP, academic reports, etc.)

I grant OT4LIFE permission to exchange information via written and mailed report, phone call, meeting, email, and/or fax.

I understand that this authorization will remain valid until written revocation of this authorization is presented.

\_\_\_\_\_  
Print Name of Child/Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian/Legal Representative

\_\_\_\_\_  
Relationship to Child/Client