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Providing Occupational & Speech Language Therapy Services for Children Birth to 21+

RELEASE OF INFORMATION AUTHORIZATION

TO: _____ **Phone:** _____
Name of facility or provider responsible for records

_____ **Fax:**_____
Street address of facility or provider responsible for records

_____
City, State and Zip of facility or provider responsible for records

RE: _____, _____
(Patient/Child's First and Last Name) (DOB)

I, _____
(Parent/Guardian First and Last Name)

Authorize the release of the following records for my minor child listed above, to Pediatric Sensory Therapy. Please mail or fax all records marked below to the address/number listed above.

Check all that apply:

- ☐ Evaluation
- ☐ Chart Notes (treatment/clinical records)
- ☐ Progress Reports
- ☐ Narrative reports (treatment reports)
- ☐ IEP/IFSP
- ☐ X-ray report
- ☐ MRI
- ☐ CT Report
- ☐ Lab Report
- ☐ Other_____
  _____

This authorization is limited to the dates of records from _____ to _____.

Thank you for your immediate attention to this request. If you have any questions, do not hesitate to call our office at 503-477-9527.

This authorization and the information obtained with it is limited to use by this office and will not be transferred or shared with any other agencies or persons. This consent will expire in 180 days from the signature date.

Signature of parent/legal guardian: _____ Date: _____
Relationship to Patient: _____