Coastside Pediatric Therapy Center

CONSENT FOR RELEASE OF INFORMATION

My signature below will constitute my consent for the release and exchange of pertinent educational, medical / audiological, and psychological records relative to my child:

_____, birthdate _____

between Maureen Barton's Occupational Therapy Service at Coastside Pediatric Therapy Center

and _____

_____

primary care physician _____

Address: _____

Telephone: _____

I understand that the records released will be kept confidential by the receiving person or agency and used for professional purposes disclosed to me.

I further understand that as parent or legal guardian I have the right to review my child's records and to withhold any records that I do not wish to be forwarded to the above person or agency.

_____ _____

Signature of Parent / Guardian Date

_____

Address

_____

City, State, Zip Code

_____

Home Phone

255 Main Street Half Moon Bay, CA 94019 (650) 560-9471 FAX (650) 560-9428