"Now We're Talking"
Pediatric Therapy, Inc.

Authorization of Release/Receipt of Patient Information

Patient Name: _____ Date of Birth: _____

I hereby authorize "Now We're Talking" Pediatric Therapy, Inc to release and receive information in my patient record to: (***i.e; CDSA, Pediatrician, Specialists, additional caregivers etc.***)

_____

_____

_____

_____

_____

This request shall be valid for duration of treatment, unless previously revoked or otherwise indicated (specify number of days or months):_____.

Reason For Release: _____
Other information:_____

I understand that by signing this form, that I hereby agree and authorize to the release of patient information to the above named person or organization. I have the right to revoke this authorization, in writing, at any time by sending such written notification to "Now We're Talking" Pediatric Therapy, Inc office address. However, I understand that my revocation will not be effective to the extent that action based on this consent has been taken.

_____ _____
Signature/ Relationship Date

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www.nowweretalkingpt.com