Children's Therapy Connections
kidsconnectnow@gmail.com ~ ph. 708-226-9200

MEDICAL AND COMMUNICATION RELEASE FORM

I, _____, parent of _____ born on _____, hereby authorize the release of medical information listed below to Children's Therapy Connections.

MEDICAL RECORDS AND INFORMATION RELEASED

I, authorize _____ (name of physician, medical group etc.) to release medical records to Children's Therapy Connections:

- **All medicals on file**

PURPOSE OF RELEASE

I give permission for this medical information to be used for the following purpose:

- **To have a complete picture of the child's history**
- **I do not give permission for any other use or re-disclosure of this information**

FUTURE MEDICAL RECORDS

I give permission for the following **future** medical records to be released to Children's Therapy Connections:

- **Any records pertaining to the child's therapy and progress**

LIST OF PHYSICIAN/THERAPISTS TO RECEIVE MEDICAL RECORDS AND INFORMATION

Pediatrician: _____ Phone number: _____

Specialist (ENT, GI, etc.) _____Phone number: _____

Therapist: _____Phone number: _____

PARENT SIGNATURE _____

THERAPIST SIGNATURE _____