# Therapy Innovations

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## Consent For Release of Patient Information

I hereby authorize **Therapy Innovations** to release information in _____ record to:

- O Our Physician _____
- O My child's preschool/school _____
- O Other: _____
- O Other: _____

The purpose of the exchange of information is to coordinate patient care. This request is valid for one year from the date of signature.

This document has been explained to me and I understand (1) the contents that are to be released, (2) why the information is needed, and (3) that there are regulations protesting the confidentiality of the above authorized information. I acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I also acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has already been taken.

_____
Patient Name (Print) Date of Birth

_____ _____
Patient/Spouse/Parent/Legal Guardian (Signature) Date Witness Date