AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL RECORDS AND INFORMATION

CHILD'S NAME: _____
DOB: _____

I hereby authorize Sensory Kids Therapy Services (check all that apply)

_____ Release information to _____ Gather information from ____
Exchange information with_____

Name of Person or Organization: _____

Address: _____

Phone: _____

Email: _____

Signature of parent/guardian: _____

Printed name: _____

Date: _____