TreeHouse
Speech-Occupational-Physical
THERAPY

RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize and request that copies of my child's prior medical records related to physical, occupational, speech and feeding evaluation and treatment services be delivered to Treehouse Therapies, LLC to establish or continue my health care treatment plan. This includes complete assessment, most recent plan of treatment, progress summary, treatment notes, and other appropriately related documents or information.

I understand that for the purpose of the continuing and coordinating my child's plan of treatment, Treehouse Therapies, LLC may be asked to release copies of my medical records, or such portions thereof, to other health care providers, facilities (related school or daycare staff, case managers, school system, Early Steps, etc) and appropriately related professionals involved in my child's care. My signature below indicates that I hereby authorize the release and disclosure of my protected health information to the following people on an as-needed basis as determined by Treehouse Therapies, LLC (choose all that apply):

☒ Release to other Entity or Individual:
_____

☒ Physician(s) ☒ School Staff ☒ Daycare Staff ☒ Early Steps
☒ Related Professional Service Providers

This authorization will EXPIRE upon my discharge from patient services or upon my written request to deny future releases.
□ **Any individuals or entities that I DO NOT want my child's health information released to are listed specifically below:**

Patient/Authorized Representative Signature

I have read and fully understand the content of this consent and authorization release and hereby agree to and authorize the foregoing provisions.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____Date: _____