



CONSENT FOR RELEASE OF INFORMATION

I hereby give permission for designated healthcare providers to transmit to Wauwatosa Therapies, LLC., any medical, therapy or laboratory reports that may be of assistance in assuring continuation of the client's health plan.

Child's Name (Please Print)

Parent/Guardian Signature

Date

List of approved organizations: (please provide address, fax number, and contact person)

1. _____

2. _____

3. _____

I give authorization to Wauwatosa Therapies, LLC., to release records (including, but not limited to: evaluation, treatment summaries, and progress reports) for reimbursement and continuation of care purposes.

Child's Name (Please Print)

Parent/Guardian Signature

Signature (Witness)

Date