Children's Therapy Associates, Inc.

Authorization for Release of Records

Child's Name: _____

Child's Birthdate: _____

I authorize the following persons, agencies or programs to exchange verbal and or written communication/ information regarding my child and family. All relevant records and information can be released between agencies as necessary. I am aware that this information is confidential and is to be used in the best interest of my child.

The agencies/individuals/programs that I authorize to exchange information include:

- ☐ Children's Therapy Associates, Inc.
- ☐ Manatee County Schools
- ☐ Sarasota County Schools
- ☐ Child Find/FDLRS
- ☐ Early Steps/Sarasota Memorial Hospital
- ☐ Early Intervention Program
- ☐ Children's Medical Services
- ☐ Manatee Memorial Hospital
- ☐ Columbia Blake Hospital
- ☐ All Children's Hospital
- ☐ Insurance: _____
- ☐ Other: _____
- ☐ Other: _____

The following records may be exchanged:

- ☐ Physical/Health/Medical
- ☐ Developmental Assessments
- ☐ OT/PT/Speech/Language
- ☐ Cognitive Development
- ☐ Hearing Evaluation
- ☐ Vision Evaluation
- ☐ Family Assessment
- ☐ Self Help/Adaptive Behavior
- ☐ Other _____
- ☐ Other _____

This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS related conditions, drug and/or alcohol abuse/conditions and/or psychiatric or psychological conditions. Information will not be disclosed to any other party without prior written consent of the parent or legal guardian and will only be shared with persons with a legitimate interest. I give consent for the agencies and programs listed to share information, effective for duration of treatment. I understand my rights in regard to this consent.

_____	_____	_____
Name of Parent/Guardian	Signature of Parent/Guardian	Date of consent

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