Children's Therapeutics of Austin

3211 Hancock Dr.
Austin, TX 78731

Phone: 512-533-9313
Fax: 512-533-9317

MEDICAL RELEASE AGREEMENT

I, ____, give permission for my
(Parent or Legal Guardian)

child's therapist(s):____

at Children's Therapeutics of Austin to discuss and provide confidential medical information regarding my

child's therapeutic intervention with ____.
(Person/ Group to Release Information to)

The disclosure of medical information is requested for the purposes

of____.
(Reason for Disclosure of Information)

The following documents and/or communication is requested:

- ☐ Evaluation Report
- ☐ Progress Report
- ☐ Ongoing communication via email, phone call From:_______________ Until: ____________
- ☐ Other:____

Child's Name____DOB: ______________________________

____ ______________________
Signature Date

____
Printed Name

If no specific start and end date are given, this authorization will expire the sooner of; two years from the date of initiation, or when the patient is of age (18 years old).