CHILDREN'S THERAPY PLACE INC.
AUTHORIZATION FOR DISCLOSURE

Client Information

Client Name _____Date of Birth _____

Mailing Address _____ State _____ Zip Code _____

Requestor Information to be completed if authorization is being made by someone other than the subject of the information.

Requestor Name _____Children's Therapy Place_____Telephone_323-8888

Relationship _____Habilitative Intervention/Support Provider_____

Address_6855 W Fairview Ave Ste 120, Boise_____State___ID_____Zip_83704_

Authorization Details

I authorize the following

_____

To disclose this confidential information to __Children's Therapy Place_____

Address____6855 W Fairview Ave Ste 120, Boise ID 83704_____

Fax____323-8889_____Phone_____323-8888_____
For the purpose of _____Habilitative Intervention_____

Please describe in detail the information to be disclosed

_____
_____
_____

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization.

Your signature Date