Children's Therapy Place, Inc.
6429 W. Interchange Lane
Boise, ID 83709
Phone: 208.323.8888 Fax: 208.323.8889
Email: info@childrenstherapyplace.com

Authorization to release or receive information. For professional use only.
Relationship to participant: Therapy Provider

Participant Name: **Date of Birth:**

I authorize the following:

Provider Name: Health and Welfare

Provider Address:

Provider Phone/Fax:

Information being requested for release:

☐ - SIB-R
☐- History and Physical
☐ - Medical/Social
☐ - Individualized Education Plan (IEP)/Eligibility
☐ - Speech/Occupational/Physical Therapy Evaluation
☐ - Plan of Service
☐ - Addendum
☐ - Implementation Plan
☐ - Status Review
☐ - Other: _____

Reason for Request:

This consent will expire one year from the date below. By signing below, I hereby authorize Childrens Therapy Place, to release/receive information from the above agency and release Childrens Therapy Place, from any responsibility and liability concerning the release of information. I understand that I have the right to revoke this consent at any time in writing.

Participant/Guardian Signature:

Date:

A copy of the completed and signed authorization form will be made available upon request.

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Relationship to participant: Therapy Provider

Participant Name: **Date of Birth:**

I authorize the following:

Provider Name: School

Provider Address:

Provider Phone/Fax:

Information being requested for release:

☐ - SIB-R
☐- History and Physical
☐ - Medical/Social
☐ - Individualized Education Plan (IEP)/Eligibility
☐ - Speech/Occupational/Physical Therapy Evaluation
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Authorization to release or receive information. For professional use only.
Relationship to participant: Therapy Provider

Participant Name: **Date of Birth:**

I authorize the following:

Provider Name: Dr.

Provider Address:

Provider Phone/Fax:

Information being requested for release:

☐ - SIB-R
☐- History and Physical
☐ - Medical/Social
☐ - Individualized Education Plan (IEP)/Eligibility
☐ - Speech/Occupational/Physical Therapy Evaluation
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