

570 West Crossville Road ● Unit # 104 ● Roswell, GA 30075

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**Consent for Release/Exchange of Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the release/exchange of information regarding my child’s therapy which may include the following: (Please check each one that you agree to)

1. ◊ Evaluation reports
2. ◊ Progress notes
3. ◊ Verbal communication with other therapists your child is seeing.
4. ◊ Verbal communication with classroom teachers.
5. ◊ Physicians
6. ◊ Insurance companies
7. ◊ Please provide any others not mentioned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read and understand Bright Horizons Pediatric Therapy, LLC consent for release/exchange of information and agree to abide by it.

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Child’s Name Date of Birth

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Parent/Guardian Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature