WAUWATOSA THERAPIES, LLC
PEDIATRIC THERAPY SPECIALISTS

CONSENT FOR RELEASE OF INFORMATION

I hereby give permission for designated healthcare providers to transmit to Wauwatosa Therapies, LLC., any medical, therapy or laboratory reports that may be of assistance in assuring continuation of the client's health plan.

_____ _____
Child's Name (Please Print) Parent/Guardian Signature

_____
Date

List of approved organizations: (please provide address, fax number, and contact person)
1._____
_____
2._____
_____
3._____
_____

I give authorization to Wauwatosa Therapies, LLC., to release records (including, but not limited to: evaluation, treatment summaries, and progress reports) for reimbursement and continuation of care purposes.

_____ _____
Child's Name (Please Print) Parent/Guardian Signature

_____ _____
Signature (Witness) Date