Children's Therapy Associates
MfoosanerPT@gmail.com
415-606-9773

Patient Consent to Release and/or Exchange Information:

Date:_____

Patient's Name: _____Date of Birth: _____

Children's Therapy Associates (CTA) will not release nor exchange your/your child's information with other healthcare professionals outside of CTA (other than a physician from which you/your child received a prescription/referral/medical clearance) without your consent. Please fill in the information in the box below if you'd like to give CTA your consent to share your child's records, and **please initial and sign at the bottom of the page**.

I, _____, grant Children's Therapy Associates consent to release and/or exchange information to/with the following professionals/caretakers involved in my/my child's care:

Name: _____
Title/Relationship to you/your child:_____
Address: _____
Phone number: Office: _____

Name: _____
Title/Relationship to you/your child:_____
Address: _____
Phone number: _____

Name: _____
Title/Relationship to you/your child:_____
Address: _____
Phone number: _____

I give Children's Therapy Associates my permission to correspond by email, fax, or phone with myself or any of the above providers regarding my child's care, and to transfer or store medical notes online as needed.

Please initial:_____

Signature of patient/parent/guardian providing consent: _____

Relationship to Patient: _____Date: _____