Interact Pediatric Therapy Services
5500 W. Friendly Ave. Greensboro, NC 27410

Consent For Release Of Client Information

Client Name:______________________ **DOB:_______________**

I, ______________________ authorize ______________________________
Name **Name of agency or person to release info**

to release specific information to Interact Pediatric Therapy Services, PLLC and I authorize Interact Pediatric Therapy Services, PLLC to release specific information to __________________________________
Name of agency or person to receive info

The information to be disclosed should include the following:
____
____
____

And will be used for ____

I understand the contents to be released, the use of the information and that there are federal and state regulations protecting the confidentiality of authorized information and that it cannot be released without my written consent unless otherwise provided for in the regulations. I acknowledge that this consent is voluntary and is valid for a one year. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken. I understand that revocation of consent must be in writing.

______________________________ _______________________
Client (or Parent/Legal Gaurdian) **Date of consent**

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Witness

www.interactpeds.com Deanna@interactpeds.com 336-772-5499