thera kids associates

RELEASE OF INFORMATION

I _____ authorize that Thera+Kids Associates (including Ms. Lori A. Gross and all of the professionals, healthcare providers, groups and individuals working with Thera+Kids and thier clients) may communicate and consult to discuss my child's treatment, progress, health and safety as deemed appropriate by the aforementioned individuals.

☐ I understand that signing this release supports the continuity of care for my child.

☐ I understand that I am not obligated to sign this release.

Physician_____ Phone _____

Therapist/Discipline _____ Phone _____

Other _____ Phone _____

_____

Parent/Guardian Name (please print)

_____ _____

Parent/Guardian Signature Date

Submit