Child's Nature, LLC
120 Eastgate Dr.
Washington, Il 61571
(309) 423-3111 (309)416-0381 fax

Child's Name: _____

Date of Birth: _____

Who referred you to our office? _____

Child's primary care physician: _____

I authorize Child's Nature, LLC to release/obtain the following information to/from the following providers to be disclosed by verbal and/or written communication

Obtain	Release	Service	Program Name	Teacher/Therapist	Phone #	Dates
		Pediatrician/physician				
		Child Care Program				
		Preschool				
		School				
		Occupational Therapist				
		Speech Therapist				
		Counselor/psychologist				
		Infant Learning Program				
		Head Start Program				
		Caseworker/care coordinator				
		Dietitian				
		Specialty Doctor				
		Other				

This information is needed for the following purpose(s): To provide communication among service provider team. This consent for disclosure is valid until patient is discharged from therapy.

I understand that I have the right to inspect and copy the information to be disclosed. I understand that I may withdraw this consent by written request at any time. I understand that my refusal to consent to disclosure will have the following consequences, if any: Information will not be disclosed.

_____ _____

Signature of Parent/guardian of Patient **Date**