Therapy Talk
Pediatric Speech, Occupational and Physical Therapy

Authorization for Release of Records

Child's Name:_____ Date of Birth:_____

Parent's Name:_____

As parent or legal guardian, I hereby authorize (list agency name, address, phone number):
_____
_____
_____
to disclose specific health information for the records of the above named child to:

Therapy Talk
140 Cabarrus Avenue West
Concord, NC 28025
704-239-6321 844-708-0619 fax

For the following purposes _____
Specific information to be disclosed (check all that apply)

____Social and Developmental History
____Physical or Occupational Therapy Evaluation
____Speech Language/Feeding Evaluation
____Educational Evaluation
____Other _____

____Individual Family Services Plan (IFSP)
____Plan of Care/Treatment Plans
____Progress Notes
____Developmental/ Multidisciplinary Evaluation
____Other _____

I request the following limitations _____

I authorize Therapy Talk to release the above information to the agency/individual/company listed above. I understand that this authorization will expire on the following date, event, or condition -_____
Or I can revoke this authorization at any time.

Signed:_____Relationship to child _____Date:_____