106 East 25th Ave.
Covington, LA 70433
985-327-5352

Release of Information Form

Child's Name_____ Date of Birth _____

This form allows Theraplay Pediatrics to send and receive evaluations, reports, and other requested information, including sending claims to your insurance provider.

I hereby authorize any physician, clinic, hospital, institution, or school to release Medical and Psychological information regarding my child,
(Patient's Name) _____to Theraplay Pediatrics. I understand that this information is to be used for professional purposes only and that it will be regarded as confidential. I also authorize Theraplay Pediatrics to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

I hereby authorize Theraplay Pediatrics to release therapy reports regarding my child,
(Patient's Name) _____, to any entity or professional associated with my child's care (physicians, any clinic, hospital, institution, insurance company, school, and other).

Photo/Video Release

I give my permission for Theraplay Pediatrics to photograph and/or videotape my child, and use said photos/videos for promotional or teaching purposes. This consent may be revoked at any time through a written request to Theraplay Pediatrics.

Theraplay Pediatrics has a website and two active social media accounts. Please circle yes or no regarding your consent to use photo or video on the these platforms.

Website: Yes No

Facebook: Yes No

Instagram: Yes No

Parent/Guardian Signature_____

Date: _____