



# CHILDREN'S THERAPY CENTER

*Celebrate what is. Commit to what can be.*

Phone: 253-854-5660

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www.ctckids.org

**Kent**  
10811 SE Kent-Kangley Rd.  
Kent WA 98030

**Burien**  
127 SW 156<sup>th</sup> St.  
Burien, WA 98166

**Tacoma**  
8717 S Hosmer St.  
Tacoma, WA 98444

## RELEASE OF INFORMATION

I, **(Parent/Guardian)** \_\_\_\_\_, hereby grant consent for Children's Therapy Center to give and/or receive information pertaining to the Physical/Occupational/Communication/Oral Motor Therapy, Prosthetic/Orthotic programs and/or Education programs for **(Child's Name)** \_\_\_\_\_ **(other names known by)** \_\_\_\_\_ **(Child's Date of Birth)** \_\_\_\_\_ with the professionals or agencies listed below for the purpose of coordination of care. Records released may include all information concerning any testing, diagnosis or treatment related to HIV, STD, psychiatric and/or drug/alcohol. A photocopy of this document shall be considered to be as valid as the original.

**Please list names of people who help you with your child, including primary physician, public health nurse, therapists, specialists, day care staff, and other agencies:**

Contact Person's Name	Agency/Clinic Name and Address	Phone #
Doctor (Primary):		
Doctor (Other):		
Hospital:		
Public Health Nurse:		
School District:		
Caseworker:		
Physical/Occupational/Speech Therapist:		
Childcare/Daycare Provider:		
Other:		

**Rights:** I understand I do not have to sign this release in order for the patient to receive services (treatment, evaluation, or enrollment). However, I do have to sign a release form in order for the organization to share information regarding the patient on my behalf. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

\_\_\_\_\_  
**Signature of Parent or Legal Guardian**                      **Relationship to Child**                      **Date**

**Expiration:** This release will be valid for the patient's duration of participation in our programs and will expire one year after the patient's discharge. This release may be revoked at any time by the above signed through submission of a written and signed statement. Revoking this release of information will not impact information released prior to the date of the written revoke request.