CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Child's Name:____ Birthdate:______________________________________
Address:____City:________________________Zip:_______________
Parent/Guardian:____Relationship to child:___________________________

By signing below, I grant my permission for the release and exchange of information pertaining to my child's medical, physical, educational and social/emotional condition and treatment between Sara S. Kemp and the following parties. I understand that I may revoke this consent at any time by giving notification in writing, except to the extent that action has been taken in reliance on it.

Information may be exchanged between
Pediatric Therapy Associates
Speech-Language Pathologist
2401 Bristol Court SW #D-103, Olympia, WA 98502
360-357-3339 Phone
360-528-3018 Fax
sara@pediatrictherapyolympia.com

~~and~~

	Name	***Address***	***Phone***
Physician			
School District			
Other therapists			
Other specialists			
Other			

____ ______________________
Parent/Guardian Signature Date

This form is the property of:
Pediatric Therapy Associates

2401 Bristol Court SW ● Building D, Suite 103 ● Olympia, WA 98502 ● (360) 352-6360