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 Janet L. Shefferly 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
Janet L. Shefferly OTR/L, INC.
Occupational Therapist
2401 Bristol Court SW #D-103, Olympia, WA 98502
360-786-9400 Phone & Fax
janet@pediatrictherapyolympia.com

~~and~~

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

_____ _____
Parent/Guardian Signature Date

This form is the property of:
Janet L. Shefferly, OTR/L, INC.