the madison center
pediatric speech & occupational therapy

consent for release form

Patient's Name ______________________ Date of Birth ___/___/___

Parent/Guardian Name ______________________

◯ I authorize The Madison Center to release and/or obtain information about the above patient, from the list below.

primary care physician

Name ______________________ Title ______________________

Organization ______________________ Phone ______________________ Email ______________________

insurance company

Name ______________________ Title ______________________

Organization ______________________ Phone ______________________ Email ______________________

school district/teacher

Name ______________________ Title ______________________

Organization ______________________ Phone ______________________ Email ______________________

other

Name ______________________ Title ______________________

Organization ______________________ Phone ______________________ Email ______________________

information to be released — *goals/objectives, progress, observations, recommendations.*
I give permission for The Madison Center staff to communicate using electronic mail with the above person(s) and/or myself regarding my child. I understand that this authorization takes effect the day that I sign it.

It expires on ___/___/___ or no more than one year from the date of my signature.

I also understand that I may change this authorization at any time.

Signature of Parent/Legal Guardian ______________________ Date ___/___/___