INTEGRATED CHILDREN'S THERAPIES, INC.
where children make connections

RELEASE AND REQUEST OF INFORMATION

Dear Health Care Professional:

The patient named below is has been seen at Integrated Children's Therapies, Inc. for an evaluation and/or treatment. Below is a release signed by the patient's guardian for the request of information and release of communication between Integrated Children's Therapies, Inc. and yourself regarding information that is relevant to your patient's/student's care. Please retain a copy of this request with your records. Thank you.

Patient's Name: _____ **Date of Birth:** _____

Guardian's Name: _____ **Relationship:** _____

I HEARBY AUTHORIZE THE FOLLOWING HEALTH CARE PROFESSIONAL TO RELEASE COMPLETE INFORMATION FROM THE MEDICAL, SCHOOL, SOCIAL SERVICE AND/OR PSYCHOLOGICAL RECORD OF THE ABOVE NAMED PATIENT TO:

Integrated Children's Therapies, Inc.
2 Coolidge Street
Hudson, MA 01749
P: 978-568-8800 F: 978-568-8877

I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that treatment, payment, or eligibility of benefits can not be conditioned on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Name of Health Care Professional: _____

Address: _____

Phone Number: _____

SIGNATURE: _____ **DATE:** _____