



PO BOX 587, Lexington NC 27293  
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## CONSENT TO RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

I hereby authorize \_\_\_\_\_

To release patient information to: OT4KIDS, INC.  
P.O. Box 587  
Lexington, NC 27293

I hereby authorize **OT4KIDS, INC.** to release specific information regarding my treatment to:

\_\_\_\_\_

I understand that this information may be communicated through written, oral, or electronic means.

**\*\* Re-disclosure of confidential information is prohibited without client consent. \*\***

The information should be limited to include only that of the nature and to the extent which is specified here:

Medical and any other information pertinent and necessary to provide appropriate occupational therapy.

**The purpose of this release is:** To assure the provision of appropriate occupational therapy or physical therapy.

In accordance with the doctrine of informed consent, I understand the contents to be released and/or exchanged, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary. I further understand that I may revoke this consent at any time except that action based on this consent has been taken.

This consent shall be valid for one (1) year, until: \_\_\_\_\_.

\_\_\_\_\_  
Patient's Signature

**OR**

\_\_\_\_\_  
Parent, Guardian, or Legally Appointed Representative's Signature:

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date of Consent