Kids Therapy, Ltd.

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Lake Barrington, IL 60010
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CONSENT FOR RELEASE OF INFORMATION

Please sign the following in order to allow other care providers to transmit information to Kids Therapy.

> I hereby give permission for designated healthcare providers to transmit to Kids Therapy any medical, therapy or laboratory reports that may be of assistance in helping to assure continuation of the client's health plan.

_____ _____
Child's Name (Please Print) Parent/Guardian Signature

_____
Date

Your signature on the following will allow Kids Therapy to release records (including, but not limited to, evaluation, treatment summaries, and progress reports).

_____ _____
Child's Name (Please Print) Parent/Guardian Signature

_____
Date

_____ _____
Signature (Witness) Date