Pediatric Therapy Services

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# Selective Release Form

Patient's Name:_____________________________________ DOB: ___________

I give my consent to Step by Step Pediatric Therapy Services to exchange information with:

___________________________________________________________________

Type of information to be shared:

___________________________________________________________________

___________________________________________________________________

I understand that this release is valid as long as__________________ is serviced by Step by Step Pediatric Therapy Services.

This consent shall not be used for the release of confidential, HIV-related information without additional specific consent.

___________________________________________________________________

Print Name of Patient (if over 18) or Parent/ Surrogate or Legal Guardian

___________________________________________________________________

Signature

___________________________________________________________________

Witness Signature.

_________________________

Date