BY YOUR SIDE™
Autism Therapy Services

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Child: _____ **Birth date:** _____

BY YOUR SIDE requests the Parent _____(parent name(s)) to authorize the person and/or agency named below to release specified records containing confidential information regarding the above named individual on this date of _____. The purpose of this disclosure is to assist in providing appropriate health care in the therapy setting.

Information requested from (please list name of person and/or agency):

_____

Please check the specific request:

- ❑ IEP
- ❑ Medical/Health History
- ❑ Reports: _____
- ❑ Other (please describe)

_____

_____

Send requested information to: _____

_____

_____

Please check **YES** only if you agree that the statements are correct. If the statements are not correct, check **NO.** If you wish to have more information or if you have any questions, please call the Center.

- ❑ YES
- ❑ NO

I have been fully informed and do understand BY YOUR SIDE -Autism Therapy Services request for my consent for release of my child's records as described above. This information will be released upon receipt of my written consent. I understand that my consent is voluntary and may be revoked in writing at any time.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date