
Release of Information From
Children's Therapy Services Early Intervention, to another entity

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Date of Request: _____

Home Address: _____

I hereby authorize Children's Therapy Services Early Intervention to release to
_____ the following information (please check all that apply):

- ☐ IFSP/IEP
- ☐ Evaluation Report
- ☐ Annual Review
- ☐ Medical/Developmental History
- ☐ Other: (Please specify) _____

All information released is for the expressed purpose of developing and integrating an effective plan of treatment for the above named child. I understand that this information is confidential and will only be viewed by professional individuals involved in my child's care.

I understand that I have the right to cancel this authorization at any time.

Parent/Guardian Signature

Date