  
**Authorization for Release of Confidential Information:**

I hereby authorize and request **Kidspiration Pediatric Therapy Services, Inc, Kidspiration Outpatient Services, and Kidspiration Behavioral Health**. to furnish all information concerning my history, treatment, examinations, hospitalizations, etc. including copies of medical records to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Person: Leah Coleman  
  
I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent of the patient named below, give Kidspiration Pediatric Therapy Services, Inc. permission to obtain from or give to the above named agency/person pertinent, social, medical, or other information as listed below. I understand that this information is confidential and will only be used for the benefit of this patient. I understand that this information may be subject to re-release by the recipient without the knowledge or consent of Kidspiration Pediatric Therapy Services, Inc. and that these companies are in no way responsible for this action. I further understand that this consent form is valid for the duration of the patient’s treatment and I may revoke this release at any time by requesting this in writing and submitting to this office.

**Documents to be released:**

\_\_\_ Behavioral Health Records

\_\_\_ Medical evaluation and/or medical record

\_\_\_ Psychological Evaluation  
\_\_\_ Educational IEP or IHP  
\_\_\_Occupational, Physical, Speech Therapy Evaluations & Goals/Treatment Plan  
\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose for release:**  
\_\_\_ At request of the parent/guardian  
  
Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
  
x \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Signature of Legally Responsible Adult Relationship