Carney
Rehabilitation & Developmental Services, PLLC.

CONSENT FOR RECIPROCAL RELEASE OF INFORMATION

Child: _____ DOB: _____

I, _____ (Parent) authorize the following:

1. _____ Physician/Therapist

to release the following information to Carney Rehabilitation and Developmental Services, PLLC.

_x_Signed physical exam form _x_Medical history

_x_Hearing Exam _x_Vision Exam

_x_Other__as requested_____

2. Carney Rehabilitation and Developmental Services, PLLC to share the following information with _____ Physician/Therapist

_x_Assessment results _x_Treatment plan

_x_Progress summaries as requested

_x_Other____as requested_____

_____ _____

Parent Signature Date