CONSENT FOR RECIPROCAL RELEASE OF INFORMATION

MEDICAL

Child: ____ DOB: __________________________

I, ____ (Parent) authorize the following:

1. ____ Physician

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

_x_Assessment results _x_Treatment plan

_x_Progress summaries as requested

_x_Other____as requested______

3. Carney Rehabilitation and Developmental Services, PLLC to use the following Email domain: @carneyrehab.com to communicate with myself and other involved professionals (as listed on consent forms).

Parent email address:____

____ __________________________________

Parent signature Date

PO Box 9983 The Woodlands, TX 77387 Phone (832)269-1254 Fax (832)442-5119

CONSENT FOR RECIPROCAL RELEASE OF INFORMATION

SCHOOL

Child: ______________________________________ DOB: ___________________

I, ____ (Parent) authorize the following:

1. ____ (School/Preschool) to release the following information to Carney Rehabilitation and Developmental Services, PLLC.

__Educational history __Examples of work/handwriting

__Teacher/staff concerns __Classroom functioning

__Other____________________________ __Language and social skills

2. Carney Rehabilitation and Developmental Services, PLLC to share the following information with ____(School/Preschool)

__Assessment results __Treatment plan

__Progress summaries as requested __Recommendations for carryover

__Other____

This consent is voluntary and can be withdrawn at any time in writing from the parent.

____

Parent signature Date

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