# A STEP AHEAD PEDIATRIC THERAPY, Inc.

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**PERMISSION FOR**
**RELEASE OF INFORMATION**

Client's Name: _____

I authorize A Step Ahead Pediatric Therapy, Inc. to release the following information that is the result of Evaluations and/or Therapy and/or Consultations performed and documented by Therapists and Therapy Assistants employed by A Step Ahead Pediatric Therapy.

___ All Evaluations
___ Only the Evaluations specified below:
_____
_____

___ All Plans of Care/Progress Reports
___ Only the Plans of Care/Progress Reports specified below:
_____
_____

___ All Daily Notes of Treatment
___ Only the Daily Notes of Treatment specified below:
_____
_____

___ All Consultation Documentation
___ Only the Consultation Documentation specified below:
_____
_____

The above information should be sent to:

1)_____
Name
_____
Address
_____
City, State, Zip

2)_____
Name
_____
Address
_____
City, State, Zip

3)_____
Name
_____
Address
_____
City, State, Zip

4)_____
Name
_____
Address
_____
City, State, Zip

| Signature | Relationship to client | Date |
| --- | --- | --- |