WAIVER/RELEASE OF INFORMATION

Date: _____

Student's Name: _____

DOB: _____

Address: _____

_____

Telephone: _____

Parent/Guardian: _____

As the parent/guardian of the above named child I herby give my permission for the release of any and all confidential information and material regarding my child so that it may be exchanged between the parties listed below. I also consent to their representatives discussing my child and sharing information regarding his/her status, progress and services.

This release is intended to cover all information and documents which these agencies/individuals may have and maintain regarding my child, including, but not limited to: medical/psychological records; education records; documentation of therapeutic evaluations and interventions. It is my intent that this waiver/release remain valid for one year or until such time as I may elect to withdraw it in writing. Therefore, in order that programming and service be informed and coordinated for my child, I consent to the release of material, information and documents between the parties below:

To/From: **Therapy Pros O.T. & Educational Services, PLLC**
962 Manor Road, Staten Island, NY 10314

To/From: _____
Day Care Center/Agency/Individual's Name

_____
Day Care Center/Agency/Individual's Name

Thank you in advance for your future cooperation with this request.

Yours truly,

_____
Signature of Parent/Legal Guardian