Optional Information Release Form:

It is often helpful for the carryover of services to collaborate with other professionals working with a child. This typically includes information about assessments, treatment, progress, accommodations, goals and recommendations. In addition to the service providers listed on my child's IFSP or IEP, I give permission to Giant Leaps Occupational Therapy, PC to contact and discuss my child's case with the names I have provided below as professionals working with my child.

I understand that this authorization is voluntary. I also understand that if the individual or organization is not a healthcare provider, then released information may no longer be protected by federal privacy regulations.

This authorization will begin on ___/___/___ and end on ___/___/___.

1. Entity or person to whom records will be released:____

   ____

2. Reason for release of information____

   ____

Only information appropriate to a request will be released.
Specific records to be released:

____

____

Name of entity or person to whom information will be released:

Name:

Address:

Phone:

Fax:

Name:

Address:

Phone:

Fax:

I understand that I may revoke this request at any time in writing to Tammy L. Belcher, MS, OTR/L, Giant Leaps Occupational Therapy, 612 Corporate Way, 3M, Valley Cottage, New York 10989. Giant Leaps will honor my request immediately upon receipt.

______________________________ ______________________________

Child's Name Relationship to Child

______________________________ ______________________________

Printed Name Signature

____

Date of Consent