9520 Padgett Street, Suite 104● San Diego, CA ● 92126 ● Phone: 858.866.8133 ● Fax: 858.999.2002

CONSENT TO RELEASE CLIENT INFORMATION

_____
Client Name

_____
Date of Birth

_____I authorized Blast Off Children's Therapy Services, Inc. to discuss the treatment sesssion or evaluation session and any other pertinent information such as scheduling, with the person who brings the client to the appointment. (example: grandparent, babysitter, etc.).

_____I authorize Blast Off Children's Therapy Services, Inc. to release all information concerning the client's case history, care, and treamtent to representatives of my insurance company or any other third party source of payment responsible for my bill. These records may also be released to my referring Physician.

_____I authorize Blast Off Children's Therapy Services, Inc. to obtain from and release client information to the professional agencies and /or individuals listed below:

Name	Address	State/Zip	Phone

_____
Signature of Parent /Guardian/Responsible Party Date

_____
Printed name