KIDSTRONG
PHYSICAL THERAPY

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PATIENT NAME:_____ DOB:_____

Authorization for Mutual Exchange of Information

I hereby authorize Stephanie Figlioli PT/KidStrong PT, to release and/or exchange any information pertaining to medical, academic, psychological, or sociological nature of the above named client with the following agencies/persons:

1. _____
Name of Agency/Person

_____
Street Address

_____
City, State, Zip

_____
Phone number(s)

2. _____
Name of Agency/Person

_____
Street Address

_____
City, State, Zip

_____
Phone number(s)

3. _____
Name of Agency/Person

_____
Street Address

_____
City, State, Zip

_____
Phone number(s)

4. _____
Name of Agency/Person

_____
Street Address

_____
City, State, Zip

_____
Phone number(s)

I understand that any information obtained will be treated in a professional and confidential manner and will not be transmitted to a third party without my permission. I also understand that it is my right to request a copy of all information exchanged and contest any information that I feel is incorrect. I hereby release KidStrong Physical Therapy/Stephanie Figlioli PT from all legal responsibility or liability that may arise from the release of information requested.

This consent is subject to my written revocation at any time, which shall be effective except to the extent that any action has been taken in reliance thereon. Unless otherwise revoked, this mutual exchange of information will have a 6-month expiration and shall expire on _____.

_____
Signature of Parent or Legal Guardian

_____
Date

_____
Stephanie Figlioli, PT

_____
Date