Pediatric
Therapy Associates

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Consent to Treatment and Release of Information

I authorize the staff of Pediatric Therapy Associates to:

1. Administer and perform those treatments that have been prescribed by my/my child's physician.
2. Release pertinent medical information to my/my child's physician, referring agency, or insurer and others as may be required.
3. Request and obtain medical information from my/my child's physician and other health care professionals as necessary to provide quality therapy services.

_____
Child's Name

_____
Signature of Responsible Party Date

_____
Printed Name of Responsible Party Relationship to Patient