154 S. Livingston Ave., Suite 204, Livingston, N.J. 07039 973-535-5010 pediatricpotentialsnj.com

Release

Date: _______________

I, _______________________________________ hereby give permission for
(Parent/Guardian name)
______________________________________ to release information regarding my
(Therapist name)
son/daughter ____, from Pediatric
(Child's name)
Potentials of West Essex, LLC, 154 South Livingston Avenue, Suite 204, Livingston, New Jersey 07039. ____
(Signature of Parent/Guardian)

Permission is specifically granted to release information to:
(Please list treating therapists, teachers, physicians, etc.)

Name: ___________________________ Address: ____

Title: __________________________ Phone #: ______________________ Cell: ______________________

Name: ___________________________ Address: ____

Title: __________________________ Phone #: ______________________ Cell: ______________________

Name: ___________________________ Address: ____

Title: __________________________ Phone #: ______________________ Cell: ______________________

Release of information with the following is *NOT* permitted.

Name Phone #/Cell # Specialty

Treating therapists: ____

Teachers: ____

Other: ____

I do not give permission for Pediatric Potentials to release any information regarding my child.

_________________________ ____
Child's name Signature of Parent/Guardian