Permission for Exchange of Medical Information

Date: ________________________

Child's Name: ______________________________

Date of Birth: ______________________________

Address: ______________________________
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I give permission for the following individuals to exchange medical information regarding my child named above with the Pediatric Therapy Center of Bucks County, LLC for purposes related directly to my child's care and treatment. I understand that all practitioners will demonstrate professional confidentiality regarding my child and his/her medical information.

Practitioner: ______________________________
Address: ______________________________
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Phone: ______________________________ Fax: ______________________________
Email: ______________________________

Practitioner: ______________________________
Address: ______________________________
____
____

Phone: ______________________________ Fax: ______________________________
Email: ______________________________

Practitioner: ______________________________
Address: ______________________________
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Phone: ______________________________ Fax: ______________________________
Email: ______________________________

________________________	________________________	__________
Printed Name (Parent)	Signature	Date