FIREFLY CENTER: THERAPY SERVICES FOR CHILDREN
www.fireflycenter.com
(415) 533-0324

RELEASE OF INFORMATION

Completion of this document authorizes the disclosure, use, release and/or exchange of pertinent educational, medical/audiological, and/or psychological records that may include individually identifiable health information, consistent with California and Federal law concerning the privacy of such information. Failure to provide *all* information requested may invalidate this Authorization.

Child's Name:_____ Birth Date: _____

I authorize the disclosure, use, release and/or exchange of pertinent educational, medical/audiological, and/or psychological records (as specified below) that may include individually identifiable health information between:

_____

AND Firefly Center: Therapy Services for Children, Firefly Center personnel and/or Melisa Kaye, MS, OTR/L.

This Authorization applies to the following information (select *only one* of the following):

☐ All pertinent educational, medical/audiological, and/or psychological records pertaining to my child's Occupational Therapy evaluation and treatment.

☐ Only the following records or types of information (including any dates)

_____

_____

The educational, medical/audiological, and/or psychological records will be used for providing information pertinent to Occupational Therapy assessment and treatment.

This Authorization shall be valid so long as my child is receiving any type of Occupational Therapy services from Firefly Center: Therapy Services for Children, Firefly Center personnel, and/or Melisa Kaye, MS, OTR/L, unless consent is withdrawn in writing.

Signature: _____ Date: _____
Parent or Legal Guardian

Printed Name: _____ Relationship to Client: _____