Consent For Release Form

_____ /_____

Patient's Name Date of Birth

_____

Parent/Guardian Name

◯ I authorize Star Therapy Inc to release and/or obtain information about the above patient, from the list below.

Primary Care Physician

_____

Name Title

_____

Organization Phone Fax Email

Insurance Company

_____

Name Title

_____

Organization Phone Fax Email

School District/Teacher

_____

Name Title

_____

Organization Phone Fax Email

Other

_____

Name Title

_____

Organization Phone Fax Email

Information To Be Released — goals/objectives, progress, observations, recommendations, and dates of service. I give permission for Star Therapy, Inc staff to communicate using electronic mail or fax with the above person(s) and/or myself regarding my child. I understand that this authorization takes effect the day that I sign it. It expires on_____ or no more than one year from the date of my signature. I also understand that I may change this authorization at any time.

_____

Signature of Parent/Legal Guardian Date