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CONFIDENTIAL RELEASE OF INFORMATION

Patient's Name:	Date of Birth	Date of Birth:	
Educational Records, IEP and any other rel	I to release and/or obtain information (Evaluations, Golevant information) to/from the agency, organization on ization, or individual to receive information (but not remains).	r individual designated below	
At the very least, you should list your pedia your child sees. Please use the back of thi	atrician, school system, Infant Toddler Program, and is form if you need more space.	any other medical specialist	
Name of agency, organization or individual to release/receive information	Address and/or phone number of agency, organization or individual to release/receive information (if known)	Approximate date of last visit	
1(Primary care physician/pediatrician)	1	1	
2. (School system)	2	2	
3. (CDSA/Infant Toddler Program)	3.	3	
4	4	4	
5	5.	5	
Records should be mailed or FAXed to:	J.Z. MANN, PEDIATRIC THERAPY 410 NEW BRIDGE STREET, SUITE 1 JACKSONVILLE, NC 28540 (910) 347-6003 (FAX)	1 0 A	
Other special instructions regarding this re	lease of confidential information		
Signature of Parent/Legal Guardian	Relationship to Patient	Date	