CONSENT FOR RELEASE OF INFORMATION

CLIENT:_____ DATE OF BIRTH:_____

I, _____hereby grant consent to Harbor Children's Therapy to give
(Parent or guardian)

and/or receive records and information pertaining to the medical, physical, educational, and

social/emotional condition of_____with the professionals and/or agencies
(Client)

listed below. A photocopy of this document shall be considered to be as valid as the original. Records

should be sent to:

Harbor Children's Therapy
5334 Olympic Drive, Suite 101
Gig Harbor, WA 98335

Professional/Agency Address

_____
_____
_____
_____
_____
_____
_____

_____

Signature

_____

Date