GLOBAL CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____, do hereby authorize
(Name of Client or Parent/Guardian)

Sensory Kids, LLC to release and receive any and all information pertinent to:

_____
(Last name of Client) (First) (MI) (Date of Birth)

from/to the following provider and/or facility_____
(Name of Physician/Provider and/or Facility)

_____
(Email Address) (Telephone #)

I do understand that this release and sharing of information will include, but not be limited to conversations, therapy sessions, records, reports, determinations, evaluations and factual information regarding myself and/or family member(s) who are minors. I understand that this action is taken to assist Sensory Kids in working with me and/or my family.

This authorization is voluntary and remains in effect until _____, unless specifically revoked by written notice to the agency or person. A photocopy of this release is as effective as the original.

_____ _____
DATE SIGNATURE OF PARENT/GUARDIAN