Coordination of Care/Consent to Obtain and Release Information

Client Name: _____ Date of Birth: _____

We understand the importance of coordinating and communicating with other person(s) involved in each client's care and development. Please list any other professionals working with the client with whom you would like use to collaborate.

Name: _____ Contact Information: _____

Name: _____ Contact Information: _____

Name: _____ Contact Information: _____

Name: _____ Contact Information: _____

Name: _____ Contact Information: _____

I understand that the information being obtained and/or released is for the purpose of treatment planning and the plan of care. I understand that I may withdraw from this consent at any time prior to the release of the above information and that withdrawal of this consent must be done in writing and submitted to Coleman Pediatric Therapy, LLC. I understand that the refusal to grant consent will not impede my right to obtain present/future treatment so long as the disclosure is not deemed necessary for providing appropriate clinical care.

This consent will expire 1 year from the date of signature.

_____ _____

Signature (Client 18 or older/Parent/Guardian) Date