Collaborative Pediatric Assessment and Therapies

PARENT RELEASE OF INFORMATION

Client Name:_____
DOB:_____

This will serve to notify the individual/ agency named below that I grant permission to The Waverly Group, LLC to request, obtain, and release information on behalf of my child.
This authorization does not extend to sources of information beyond the individual/ agency named in this release.

NOTE: UNLESS YOU NOTIFY US OTHERWISE IN WRITING ALL INFORMATION WILL BE COMMUNICATED TO BOTH PARENTS AND OR GUARDIANS.

The effective period of this authorization begins : _____

Coordination of Care

_____ initials — I give permission to have The Waverly Group, LLC discuss my case with the therapists and staff involved at The Waverly Group, LLC.

_____ initials — I give permission to have The Waverly Group, LLC discuss my case with all persons whose names I have provided below as professionals working with my child or myself.

_____ initials — I give permission to have The Waverly Group, LLC to send copies of progress reports to all referral and funding sources whose names I have provided.

_____ initials — I understand that the initial evaluation and bi-yearly progress reports may be sent to the referring physician, psychologist, and/or school system.

PLEASE LIST EACH NAME OF PERSON/ AGENCY YOU AUTHORIZE US TO RELEASE OR RECEIVE INFORMATION FROM:

_____
Name **Address/ Telephone Number**

_____
Name **Address/ Telephone Number**

_____
Name **Address/ Telephone Number**

_____ _____
PARENT SIGNATURE **DATE**

Please return via SCAN TO: INFO@WAVERLY-GROUP.COM OR MAIL TO:
The Waverly Group 1445 East Putnam Ave., Old Greenwich, CT