Children's Theraplay

Family-Friendly Therapeutic Intervention

CONSENT TO RELEASE PRIVATE DATA

This form allows information about your child to be exchanged.

CHILD'S NAME:		DOB:	
PARENT(S)/GUARDIAN(S):			
ADDRESS:			
PHONE:			

I authorize Children's Theraplay to:

	Release information only		Obtain information only		**Release & obtain information**

Please list only one provider/organization per consent.

PROVIDER NAME:					
AGENCY:					
EMAIL ADDRESS:					
ADDRESS:					
CITY:		STATE:		ZIP:	
PHONE:		FAX:			

Information to be released is marked below:

	All information required to coordinate care
	Other (please list specific to be released):

The information will be requested/released for this purpose:

☐ **EMAIL CONSENT:** I understand that email is not a secure confidential means of communication, and may be intercepted by a third party. I consent to allow Children's Theraplay staff to use unsecured email to transmit confidential information to the email address I have provided above. _____ **INITIAL HERE**

I understand that this authorization takes effect on the day I sign it. It expires no more than one year from the date of my signature or on the following expiration date: _____

I understand that I may change this authorization in writing at any time, but not retroactively.

Parent/Guardian Signature Date

MAPLEWOOD ▪ 2399 Ariel Street N, Suite A, Maplewood, MN 55109 ▪ 651.773.0354 ▪ FAX 651.773.0371
PLYMOUTH ▪ 3001 Harbor Lane N, Suite 120, Plymouth, MN 55447
www.childrenstheraplaymn.com