FOCUS ON KIDS TOO, INC.
Pediatric Rehabilitation and Education Centre
425 Huehl Road, Building 14A, Northbrook, IL 60062 (847) 412-9772 Fax (847) 412-9773

Authorization for Release of Medical Records
Outpatient Rehabilitation Services

Patient Name _____ **D.O.B** _____

I, ……..……(NAME OF PARENT OR LEGAL GUARDIAN) do hereby authorize *Focus On Kids Too, Inc.* to release Occupational, Physical, Speech-Language Therapy Test Results, Progress and/or Discharge Notes for the above named patient to:

(PLEASE INCLUDE COMPLETE NAME AND ADDRESS)

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

I understand that I may revoke this consent at any time by giving written notice to Focus On Kids Too, Inc. If no prior notice of revocation is received this consent will expire automatically at the time of discharge or when services are terminated. I understand that I have the right to inspect and copy the information to be disclosed.

_____ _____
Parent/Legal Guardian Signature **Date**

I attest to the identity of the above signature: _____
Witness

REPORT LOG

Date of Report	Type of Report	Sent To #	Date Sent Out	Initials