Waiver to Share Information

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| --- | --- |
| Child Name: | Parent Name: |
| Date of Birth: | Contact Information: |
| NYC ID #: |  |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ parent of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that the evaluation process is a multidisciplinary process. I hereby

* Grant permission
* Do not grant permission

for the release of any and all confidential information regarding my child. This waiver is intended to cover all individuals including but not limited to his/her evaluation team (social worker, psychologist, educational evaluator, speech therapist, occupational therapist, and physical therapist), my child’s primary pediatrician, classroom teacher and/or daycare staff. I also consent to the release of information to all related service providers providing services, regardless of agency.

It is my understanding that this waiver will remain in effect through my child’s enrollment at, **Step Up Therapy Services**. Or until such a time when I choose to withdraw it, in writing.

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Parent Signature Date