



LITTLE TESOROS
THERAPY SERVICES

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Authorization to Release Information

Patient Name

Date

I consent to the release of information and/or disclosure to LTTS of all or any part of my child's records by the following persons upon request:

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

Parent/Guardian Signature

Date

Relationship to Patient

LTTS Representative (print name as witness)

LTTS Representative Signature

Date