

Ogle County Educational Cooperative

417 N. Colfax – P.O. Box 582 - Byron, IL 61010
Phone 815/234-2722 - Fax 815/234-2938

THERAPY RELEASE OF INFORMATION

OT PT

Name of Student: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____

Address: _____

City/Zip: _____ School District: _____

This release will be valid for the _____ - _____ school year. Please complete/correct information listed above.

Parent:

In order to allow your child to receive therapy and to facilitate communication, your written request is required. Please fill in the information requested in the section below.

1. Indicate your child's primary treating physician and the name of the associated medical practice/clinic, from whom a prescription should be obtained.
2. Indicate any additional physicians and/or non-educational agencies (such as clinics) to be included in your child's treatment planning.
3. Date and sign the form before returning it to OCEC.

If you choose not to give your permission for the release of information, please read and sign the section at the bottom of this form.

Consent is requested by the OCEC for the release of written therapy reports and verbal information, and to obtain medical referrals specifically for therapy, records, reports and verbal information, regarding the therapy program of my child, to/from:

Primary Treating Physician: _____

Medical Practice/Clinic: _____ City: _____

Phone: _____ Fax: _____

Other Physicians/Agencies: _____

This consent may be revoked at any time, provided such revocation is in writing, and is signed by the person who gave the consent, and that signature is witnessed.

I give my consent.

I do not give my consent.

Date

Parent/Guardian Signature