10862 Portage St NW
Canal Fulton, OH 44614
330-408-7575

2714 Akron Road
Wooster, OH 44691
330-262-4449

Release of Information Form

Date: ____________________

Child's Name: ____

DOB: _____________________

Parent/Guardian: ____

Address: ____

Phone Number: _______________________________

I. I hereby authorize any physician, clinic, hospital, institution or school to release medical and psychological information regarding my child, ___________ (child's name) to EJ Therapy Services. I understand that this information is to be used for professional purposes only and that it will be regard as confidential. I authorize EJ Therapy Services to contact any persons or institutions to obtain any additional information regarding my child, when necessary.

Signed ______________________________ (insured)

II. I hereby authorize EJ Therapy Services to release therapy records regarding my child, _____________ (child's name), to my child's physician, and any clinic, hospital, institution, insurance company, school and other: __________.

Signed ______________________________ (insured)

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Parent's Name: ____

Child's Name: ____

Emergency Number: ____

Allergies:

____

Other Information:

____

____

Parent Permission

Publication of Photograph

I give EJ Therapy the permission to use my child's photograph for advertising, in print or on our website, Facebook, etc and / or other uses in their business.

Child's Name: ____

Parent's Name (Print): ____

Parent's Signature: ____________________________________ Date: _________