Therapy 4 Kids, Inc.
Release of Information:

Release Of Information:
Please indicate anyone (school, physician, etc..) with whom you would like us to release or exchange information.

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I do NOT wish to have my child's information shared with:
_____
_____

Insurance:
Currently we are providers for **Blue Cross Blue Shield of Oklahoma** and will file that insurance company on your behalf. If your insurance carrier contacts us requesting information on the clients file:

_____ Do not release any information
_____ Release only dates of appointments, clinician's names and diagnostic codes.
_____ Release any information requested by my insurance company.

Client's Name: _____ DOB: _____

Responsible Party (please print): _____

Signature of Responsible Party: _____

Witness: _____ Date: _____

