

AUTHORIZATION FOR EXCHANGE OF INFORMATION

PATIENT NAME _____ Date of Birth _____

Parents Names _____

Address: _____

City, State, ZIP _____

Home Phone: _____

I hereby authorize the exchange of medical records, school records, clinic notes and pertinent information regarding the treatment/program development of this patient between:



Bothell Pediatric and Hand Therapy

18504 Bothell Way NE

Bothell, WA 98011

Phone 425-481-1933 / Fax 425-481-9371

And the following facilities, but not limited to: Primary Care Physician, Referring Physician, Schools, Other Therapists, and Hospitals:

Facility Name _____

Person/Professional: _____

Address, City, State, Zip: _____

Phone/Fax: _____ / _____

Facility Name _____

Person/Professional: _____

Address, City, State, Zip: _____

Phone/Fax: _____ / _____

Facility Name _____

Person/Professional: _____

Address, City, State, Zip: _____

Phone/Fax: _____ / _____

Facility Name _____

Person/Professional: _____

Address, City, State, Zip: _____

Phone/Fax: _____ / _____

Facility Name _____

Person/Professional: _____

Address, City, State, Zip: _____

Phone/Fax: _____ / _____

Parent/Legal Guardian: _____

Phone: _____

Signature: _____

Date: _____

▶ **PLEASE USE THE BACK FOR MORE INFORMATION IF NECESSARY** ▶ ▶ ▶ ▶