NEWTOWN THERAPY
& WELLNESS CENTER

RELEASE OF INFORMATION FOR MINOR

I _____ , authorize Newtown Therapy to release and exchange information pertaining to my child's evaluation and therapy sessions to: (provide name and contact information-phone number, address and email)

_____

_____

I understand that authorization shall remain valid from the date of my signature below and for 9 months thereafter. I have been informed that I may revoke this authorization by written or email communication to Newtown Therapy. I certify that this form has been fully explained to me and that I understand the content.

_____

CHILD'S NAME

_____ _____

SIGNATURE OF GUARDIAN DATE OF AUTHORIZATION

444 S. State Street, Newtown, PA 18940