SEACOAST KEYSTONE THERAPY, LLC

Release of Information

Client's name: _____ DOB:_____

I, _____, hereby authorize Seacoast Keystone Therapy, LLC to exchange information pertaining to my evaluation or therapy sessions to:

_____for the purpose of _____

Indicate the records you are requesting to be sharing: _____

Or check this box for complete records ____

I understand that authorization shall remain valid from the date of my signature below and for twelve months thereafter ending on _____

I have been informed that I may revoke this authorization by written or oral communication to Seacoast Keystone Therapy, LLC. I certify that this form has been fully explained to me and that I understand its contents.

Parent Signature:	Date:

Deborah Guarino, OTR/L 603-988-6626
Caitlin Coleman, M. S., BCBA 603-770-0102
55 Main Street Unit #413 Newmarket, NH 03857 Fax: 603-899-7732
Emails: deb@seacoastkeystonetherapy.com caitlin@seacoastkeystonetherapy.com
website: www.seacoastkeystonetherapy.com