



**CONSENT TO RELEASE CONFIDENTIAL INFORMATION**

Applicant/Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Social Security # \_\_\_\_\_

I hereby authorize \_\_\_\_\_  
to release information to the Cerebral Palsy Association.

I authorize this to be a two-way release \_\_\_\_\_ (initial)

The following information is requested: (initial)

- \_\_\_\_\_ Medical Records
- \_\_\_\_\_ Physical Therapy Evaluations
- \_\_\_\_\_ Occupational Therapy Evaluations
- \_\_\_\_\_ Speech Evaluations
- \_\_\_\_\_ Visual Assessment
- \_\_\_\_\_ Audiological Assessment
- \_\_\_\_\_ IFSP or IP / Developmental Summary Information
- \_\_\_\_\_ Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_

The above information will be utilized for:

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Parent/Guardian or Applicant

\_\_\_\_\_

This consent will remain in effect until revoked.