



**CHILDREN'S
THERAPY**
of Woodinville, P.L.L.C.

17311 135th Ave. N.E., Ste. C-200
Woodinville, WA 98072
(425) 486-7710
FAX (425) 483-6059

**AUTHORIZATION FOR
EXCHANGE OF INFORMATION**

PATIENT: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
BIRTHDATE: _____

I give permission for the exchange of information, regarding the patient listed above, between

**CHILDREN'S THERAPY OF WOODINVILLE, P.L.L.C.
17311 135TH AVE NE, C200
WOODINVILLE, WA 98072**

and the following facilities. This includes medical records, clinic notes, school records and any pertinent information that will help in developing the patient's program.

FACILITY: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE: _____

FACILITY: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE: _____

FACILITY: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE: _____

FACILITY: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE: _____

PARENT / LEGAL GUARDIAN: _____
ADDRESS: _____
CITY, STATE, ZIP: _____

SIGNATURE OF PARENT / LEGAL GURADIAN

DATE