maple valley pediatric therapy
A Division of Relaxing Resources, PLLC

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22443 SE 240th Street, Suite 206 • Maple Valley, WA 98038

Authorization for Exchange of Information

Child's Name:_____ Date of Birth: _____

(Please print) I, _____ hereby authorize Maple Valley Pediatric Therapy, *a Division of Relaxing Resources, PLLC*, to give and/or receive information in verbal, written, electronic, or fax form pertaining to the above named client. I authorize the exchange of information between staff at Maple Valley Pediatric Therapy, *a Division of Relaxing Resources, PLLC* and the party or parties listed below:
(Please list all providers, including your primary and/or referring physician, that we may contact in order to help us better serve your child.)

Facility Name	Provider Name	Specialty	Phone	Initials	Date

A photocopy of this document shall be considered to be as valid as the original. This authorization for the release of information shall remain in effect until revoked and may be revoked by myself at any time by providing written notice to Maple Valley Pediatric Therapy, *a Division of Relaxing Resources, PLLC.* I understand that the information obtained will be treated in a confidential manner.

Name of person completing this form: _____
Please Print

Relationship to child: _____

Signature: _____ **Date:** _____