maple valley pediatric therapy
A Division of Relaxing Resources, PLLC

425.358.3070 PHONE • 425.413.6797 FAX • www.mvpedtherapy.com
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:

Having this information is to help us better serve your child.

Provider Name	Facility Name and City	Phone Number	Initials	Today's Date
Doctor (Primary):				
Specialist:				
School contact:				
Occupational Therapy:				
Psychologist:				

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:** _____