



## STATEMENT OF RELEASE

I authorize release of information to all of my Medical Insurance Carriers.

I authorize Pediatric Physical Therapy Services/Debi Abdow-Addis, MS, PT to act on my behalf in obtaining payment from my Medical Insurance Carriers.

I authorize release of Pediatric Physical Therapy Services/Debi Abdow-Addis, MS, PT medical records and other relevant information to my child's physicians, medical specialists and school personnel.

I authorize my child's physicians, medical specialists and school to release relevant records and information to Pediatric Physical Therapy Services/Debi Abdow-Addis, MS, PT.

I authorize Pediatric Physical Therapy Services/Debi Abdow-Addis, MS, PT to take my child to the nearest hospital in the event of an emergency.

I authorize Pediatric Physical Therapy Services/Debi Abdow-Addis, MS, PT to talk with me about my child's treatment in the waiting room of the office.

I permit a copy of this statement of release to be used in place of the original.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
date

\_\_\_\_\_  
Print Name of parent or guardian

\_\_\_\_\_  
Print Name of Child