piedmont music therapy

Piedmont Music Therapy, LLC
Consent For Exchange Information

I authorize Piedmont Music Therapy, LLC to release necessary and pertinent medical information to physicians, and case managers as needed for my child,

_____.
(client's name)

This information may also be exchanged with the following people directly related to my child's care.

Other Therapists:_____

School Name: _____

Please list any others: _____

_____

Approved information includes written documents and verbal discussions. This approval also applies to the exchange of information with the above indicated individuals and organizations through e-mail.

_____ _____
Parent/guardian Signature Date

_____
Printed Name