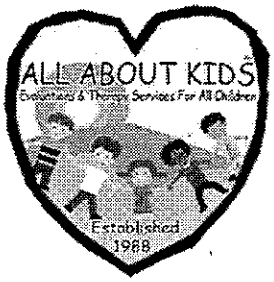


# ALL ABOUT KIDS™

Evaluations & Therapy Services For All Children

www.allaboutkidsny.com

## CONSENT TO RELEASE INFORMATION TO PRIMARY HEALTH CARE PROVIDER

Child's Name: _____ D.O.B _____
Last Name First Name

I understand that it is important for my child's primary health care provider to be aware of my child's developmental status. I give my consent to **All About Kids** to release any developmental evaluation reports of my child. This form is to be used only to release information to the primary health care provider specified below.

Physician's Name: _____

Facility: _____

Address: _____

_____

Office Number: _____ Office Fax Number: _____

This release can be withdrawn at any time by writing to **ALL About Kids** at the applicable office site below.

_____ Date _____
SIGNATURE OF PARENT/GUARDIAN

Relationship to Child: _____


| Executive Office Nassau | Suffolk | Queens Manhattan | Brooklyn | Bronx | Westchester |
|---|---|---|---|---|---|
| 255 Executive Drive, Suite LL 105/108 | 150 Vanderbilt Motor Pkwy, Suite 401 | 37-11 35th Ave, Suite 3C | 25 Chapel Street, Suite 704 | 3140B E. Tremont Avenue | 145 Huguenot Street, Suite 404 |
| Plainview, NY 11803 | Hauppauge, NY 11788 | Astoria, NY 11101 | Brooklyn, NY 11201 | Bronx, NY 10461 | New Rochelle, NY 10801 |
| **516-576-2040** | **631-439-6860** | **718-706-7500** | **718-522-7300** | **718-239-4147** | **914-251-0905** |
| Fax: 516-576-2131 | Fax: 631-439-6861 | Fax: 718-706-9595 | Fax: 718-522-5280 | Fax: 718-239-4310 | Fax: 914-251-1266 |