



**Apple Tree Therapy, LLC**

Jackie Brown, OTR/L  
Pediatric Occupational Therapist  
9951 Mickelberry Rd NW, Suite 123  
Silverdale, WA 98383  
360-286-2351

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Client/Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby authorize Apple Tree Therapy, LLC to give and/or receive in verbal, written, or email form information pertaining to the above mentioned individual.

I authorize exchange of information between Apple Tree Therapy, LLC and the party or parties listed below:

	Name	Address	Phone
Physician	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
School District	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other therapists	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other specialists	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Other	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

A photocopy of this document shall be considered to be as valid as the original. This authorization for release of information shall remain in effect until revoked and may be revoked by myself at any time by giving a written notice to Apple Tree Therapy, LLC.

\_\_\_\_\_  
Parent/ Guardian/Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Parent/Guardian/ Client Name

\_\_\_\_\_  
Relationship to Client