RELEASE OF INFORMATION

CLIENT'S NAME: ____ DOB: ___________________

ADDRESS: ____ CITY: _________________ ZIP: _____________

A. Request for Information

Please release the medical records pertaining to this client to The T.E.A.M. Approach, Inc., 13150 FM 529, Suite, 114, Houston, TX 77041.

B. Permission to Release Information

Permission is granted to The T.E.A.M. Approach, Inc. to release copies of evaluation and progress reports to insurance companies and institutions involved in ______________________'s care. Exceptions to this include:

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C. Please send copies of The T.E.A.M. Approach's evaluations to:

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D. Photo Release

Permission is granted to The T.E.A.M. Approach, Inc. to take periodic photos of ______________ to document progress, for professional education, and occasional marketing of programs.

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Name of Parent or Responsible Party | Relationship to Child

____

Signature of Parent of Responsible Party | Date

____

Witness | Date