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### Release of Treatment Information Form

I, \_\_\_\_\_, hereby allow any therapist or office personnel of Stepping Stones Pediatric Therapy, LLC to disclose necessary and pertinent information regarding the therapy treatment and medical history of my child

\_\_\_\_\_

To:

Name/ Address/ Phone Contact

1) \_\_\_\_\_  
\_\_\_\_\_

Name/ Address/Phone Contact (if more than one entity)

2) \_\_\_\_\_  
\_\_\_\_\_

The information released may contain documentation associated with provision of any of my child's medical or educational services. This shall include, but not be limited to, sharing of evaluations, progress notes, therapy treatment notes and general phone, written (script or email), or video consultations as necessary to attain therapeutic goals set forth by the family and therapy providers.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child's Name