Ridgefield Sensory Clinic, LLC
79 Danbury Road, Suite A1
Ridgefield, CT 06877
203-894-5230
ridgefieldsensoryclinic@gmail.com
ridgefieldsensoryclinic.com

AUTHORIZATION TO RELEASE INFORMATION

CLIENT NAME:____

BIRTH DATE:____

I hereby authorize Ridgefield Sensory Clinic to provide information concerning therapy evaluations and treatments of the above named client to the following people or agencies:

NAME:____ DATE:__________________

AGENCY:____ PHONE:________________

ADDRESS:____

NAME:____ DATE:__________________

AGENCY:____ PHONE:________________

ADDRESS:____

NAME:____ DATE:__________________

AGENCY:____ PHONE:________________

ADDRESS:____

This authorization may be revoked at any time upon written request. All information is considered confidential. This authorization remains in effect for one year from the date signed below.

SIGNATURE:____ DATE:__________________

PRINT NAME:____

RELATIONSHIP TO CLIENT IF CLIENT IS A MINOR:____