Release of Medical Information Form

Name: _____Birthdate___/____/_____ Age: Address: _____ City: _____ Zip: _____

Parent/Guardian Name :
_____ Home Phone: _____Work Phone: _____ Cell: Current Therapy Provider : _____

I authorize the release of information including diagnosis, records, examination/evaluation rendered to _____. The information may be released to:

Sawdust Occupational Therapy LLC
11660 Alpharetta Highway Blg 200 Ste 200 Roswell GA 30076
James@Sawdustot.com
Fax: 470-533-1522

Parent/Guardian Printed Name:
_____
Parent/Guardian Signature:
_____

Additional questions can be directed to:
James Garwacki OTR/L Co- Owner, Director of Operations
404-436-7416
James@SawdustOT.com