9596 N. McGee, Kansas City, MO 64155 vt@vseyecare.com Phone, Text, Fax: 816-398-7229

This form should be completed by the parent/guardian. It gives teachers and other professionals permission to communicate with **Vision Source Kansas City North** regarding your child as we complete his/her Vision Therapy evaluation and treatment.

The parent(s) or guardian(s) whose name appears below has a child participating in Vision Therapy through our office. As we carry out treatment, we place a high value on collaboration. In this spirit, we have provided the parent with the permission form below, which when completed will allow us to communicate freely about the child with whom we both work. Please contact us if you have any questions about this child's vision program, suggestions for modifications, spectacle wear, etc. We look forward to working with you as we strive to make a positive difference in the life of this child.

AUTHORIZATION TO RECEIVE and/or RELEASE INFORMATION REGARDING:

Name of client: _____DOB:_____

Please specify if this release is for the following professional:

School Personnel at _____
name of your child's school

- o Teacher
- o School Psychologist:
- o Special Education Teacher
- o Speech Language Therapist
- o Occupational Therapist
- o Physical Therapist
- o Other:_____

Name	Title or Position	Phone	email

_____

Print parent or guardian's name Signature Date

VISION SOURCE®
KANSAS CITY NORTH
9596 N. McGee, Kansas City, MO 64155 vt@vseyecare.com Phone, Text, Fax: 816-398-7229

AUTHORIZATION FOR RELEASE OF INFORMATION

This form should be completed by the parent/guardian. It gives **Vision Source Kansas City North** permission to communicate with School Personnel at _____ regarding your child as we complete his/her Vision Therapy evaluation and treatment.

The parent(s) or guardian(s) whose name appears below has a child participating in Vision Therapy through our office. As we carry out treatment we place a high value on collaboration. In this spirit, we have provided the parent with the permission form below, which when completed will allow us to communicate freely about the child with whom we both work. Please contact us if you have any questions about this child's treatment. We look forward to working with you as we strive to make a positive difference in the life of this child.

AUTHORIZATION TO RECEIVE and/or RELEASE INFORMATION REGARDING:

Name of client: _____ DOB: _____

Please specify if this release is for the following professional:

- ○ Vision Therapist
- ○ Optometrist
- ○ Other: _____

A separate release form may be needed for each provider.
This release is for the following provider:

Name:	Pam Beitling
Street address:	9596 N. McGee
City/State/Zip	Kansas City, MO 64155
Phone:	816-398-7229
Email:	vt@vseyecare.com

_____

Print parent or guardian's name Signature Date