



RELEASE OF INFORMATION TO CHILD'S PHYSICIAN

I hereby authorize the program medical director to disclose any and all records pertaining to my child's physician. I, on behalf of my child, hereby release the Tourette Syndrome Association of Texas and du Ballon Rouge from all legal responsibility and liability which may arise from the release of these records to the physician(s) below.

Physician Name _____ Phone (_____) _____

Address _____ State _____ Zip _____

Type of doctor (neurologist, pediatrician, etc.) _____

Physician Name _____ Phone (_____) _____

Address _____ State _____ Zip _____

Type of doctor (neurologist, pediatrician, etc.) _____

Parent or Guardian (Father) _____ Date _____

Parent or Guardian (Mother) _____ Date _____