Opportunity Networks Authorizations

Client Name: _____

Release of Information

_____ **/** _____ *Initial to authorize release of records or information to the following*
(guardian init) (co-guard init) *(please check all that apply)*

- ❑ Other: (identify exact agency) _____
- ❑ Occupational Therapist
- ❑ Physical Therapist
- ❑ Speech Therapist
- ❑ Contracted Nursing Service

****

Medical Administration (prescriptions)

_____ **/** _____ *Initial to authorize currently med trained staff of Opportunity*
(guardian init) (co-guard init) *Networks to **administer prescription medication.***

****

Authorization to receive therapy

_____ **/** _____ *Initial to authorize the following (please check all that apply):*
(guardian init) (co-guard init)

- ❑ Other: _____
- ❑ Occupational Therapy
- ❑ Physical Therapy
- ❑ Speech Therapy

****

Signatures: _____ | _____
Guardian / date | co-guardian (if applicable) / date

Relationship: _____ | _____
Address_____ | _____
_____ | _____
Phone_H_____C_____ | H_____C_____
Email _____ | _____