

Your Child's Therapists/Other Health Care Providers

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Many of our young patients see other therapists to work on areas of challenge in their development. To allow for the best co-management and to keep them informed of your child's vision health, we would like to send summaries of your child's vision evaluations to all of their health care providers. Our goal is to provide the highest quality of care and we have found that close communication with other providers has helped our patients tremendously, i.e. helping an OT know when during their session they should have your child wear glasses. Please list the names and office locations of your child's therapists below. If you do not know all of the information, we are happy to look it up for you.

<input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Yes, mail summaries of all evaluations We may communicate with your provider via: <input type="checkbox"/> Email <input type="checkbox"/> Call/Speak in Person Name Clinic Address City State Zip Phone #	<input type="checkbox"/> Physical Therapist <input type="checkbox"/> Yes, mail summaries of all evaluations We may communicate with your provider via: <input type="checkbox"/> Email <input type="checkbox"/> Call/Speak in Person Name Clinic Address City State Zip Phone #
<input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Yes, mail summaries of all evaluations We may communicate with your provider via: <input type="checkbox"/> Email <input type="checkbox"/> Call/Speak in Person Name Clinic Address City State Zip Phone #	<input type="checkbox"/> Tutor/Handwriting Instructor/ABA Therapist <input type="checkbox"/> Yes, mail summaries of all evaluations We may communicate with your provider via: <input type="checkbox"/> Email <input type="checkbox"/> Call/Speak in Person Name Clinic Address City State Zip Phone #
<input type="checkbox"/> Naturopath <input type="checkbox"/> Yes, mail summaries of all evaluations We may communicate with your provider via: <input type="checkbox"/> Email <input type="checkbox"/> Call/Speak in Person Name Clinic Address City State Zip Phone #	<input type="checkbox"/> Other _____ <input type="checkbox"/> Yes, mail summaries of all evaluations We may communicate with your provider via: <input type="checkbox"/> Email <input type="checkbox"/> Call/Speak in Person Name Clinic Address City State Zip Phone #

By signing this form, I acknowledge that the above information is true and correct to the best of my knowledge. I also acknowledge that Eastside Family Vision Care will be sending my child's protected health information to the above providers. This agreement will remain in effect until I give written notice of any changes.

Signature

Date

Staff Initials

Date