

# Authorization for Release of Information

**Parents/Guardians:** This form allows information about your child to be exchanged. Please sign and return to Special Music, Inc.

\_\_\_\_\_  
Client's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone(s)

I authorize Beth Wiskus, MA, MT-BC, NMT (Neurologic Music Therapist) to:  
(check either or both spaces that apply)

\_\_\_\_\_ Release information to: \_\_\_\_\_ Release information from:

\_\_\_\_\_  
Name/Title

\_\_\_\_\_  
Organization

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

The following information is requested:

\_\_\_\_\_ Health History (IEP/IIIP/IFSP)

\_\_\_\_\_ Physical Examination Records

\_\_\_\_\_ Immunization Records

\_\_\_\_\_ Other: \_\_\_\_\_

The purpose of this request is:

1. To facilitate evaluation of your child's individual educational program.
2. To determine health needs of your child which may require attention during treatment.
3. To provide the neurologic music therapist with a better understanding of your child's health and educational needs.

I understand that the authorization takes effect the day that I sign it and expires at the end of my child's treatment.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Special Music, Inc.  
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St Paul, MN 55106

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Email: [contact@specialmusicofmn.com](mailto:contact@specialmusicofmn.com)