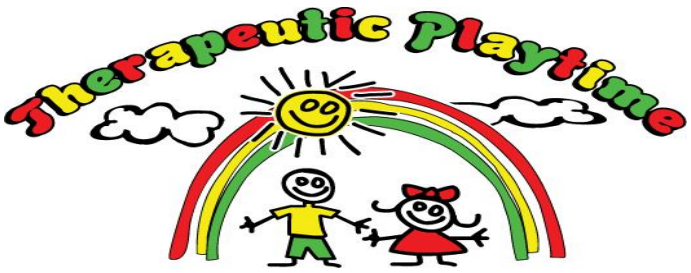

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In order for providers to be able to communicate with us (and/or each other) regarding your educational file under applicable state and federal law, we need to obtain a hand signed Educational Information Release Form ("MIRF") from you.

Educational Information Release Form-IEP (Individual Educational Plan)

The undersigned hereby grants permission to Therapeutic Playtime to discuss any and all educational bill related information with any educational practitioner, hospital, facility, insurance company or and other agency/entity that has educational records or knowledge of the educational records of the undersigned and/or the dependents listed herein.
The undersigned hereby authorizes any educational practitioner, hospital, facility, insurance company or any other person or entity that has educational records or knowledge of the educational records of the undersigned and/or the dependents listed herein, to release such information upon request to interested PARTIES (to be determined by Therapeutic Playtime) for the purpose of communicating with Therapeutic Playtime and/or for providers to be able to communicate with one another regarding your educational file.

The undersigned understands that:

- I may revoke this educational information release at any time, in writing, but the release shall remain valid until revoked or upon the expiration of one (1) year after the release is executed, whichever occurs first.
- This release may include educational records of treatment for physical and/or emotional illness.
- A copy of this form, including a facsimile, may be used in place of the original.

NOTE: Further, I authorize the disclosure of my protected health information in accordance with the terms in this Authorization.
Optional: If it is necessary for someone other than your spouse to discuss your educational bills or finances with Therapeutic Playtime, please provide the individual's name below to appoint and authorize them to act as your personal representative for this limited purpose: ("Personal Representative")

Patient's Name: _____ DOB:_____

Patient's (Or Guardian) Signature: _____

Date: _____