

**A Sound Approach Speech/Language Therapy, LLC**  
**5331 Commercial Way, Suite 101**  
**Spring Hill, FL 34606**  
**hdawes@asoundapproachslt.com**  
**Phone 352-650-2369**  
**Fax 352-204-9737**

**Authorization to Exchange, Obtain or Release Information**

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

I \_\_\_\_\_ (client or family member) hereby grant **A Sound Approach Speech/Language Therapy, LLC** permission to communicate with the following person or agency:

**Name:** \_\_\_\_\_

**Contact Information:**  
\_\_\_\_\_  
\_\_\_\_\_

**Information to Be Released:**

- Medical History
- Therapy Evaluation
- SLP    OT    PT    Other: \_\_\_\_\_
- Treatment Notes
  - SLP    OT    PT    Other: \_\_\_\_\_
- School Records (Evaluations, IEP, academic reports, etc.)

**For the Purpose Of: (check all that apply)**

- Coordinating care with other professionals
- Providing continuity of services
- Updating therapeutic progress
- Other \_\_\_\_\_

I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.

I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client or Legal Representative

\_\_\_\_\_  
Relationship to Client