A SOUND APPROACH
SPEECH & LANGUAGE THERAPY

5327 Commercial Way, Suite A102
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Phone: 352-293-8502
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