250 Georgia Ave. SE, Ste. 363, Atlanta GA 30312
**O:** 470-210-4301 I **F:** 888-975-4313
info@ispeaktherapyservices.com

# Authorization to Exchange, Obtain or Release Information

Client Name (Child): _____Date of Birth: _____
Home Address: _____
_____

I _____ (client or family member) hereby grant iSpeak Therapy Services permission to communicate with the following person or agency:
(Recipient(s) name/address/phone/fax) (School/Physician/Insurance/Other Health Professionals)_____
_____Phone:_____ Fax: _____

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.)

☐ Other: _____

**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(Child) Date

_____ _____
Signature of Client or Legal Representative (Parent) Relationship to Client