Consent to Exchange, Obtain, or Release Information

Client's Name: _____
Date of Birth: _____

For the reasons identified in this form, I hereby grant Lifeline Speech Therapy LLC permission to communicate (exchange, obtain, or release) my medical information with the following person or agency:

Name of Agency: _____
Address: _____
Name of Contact Person: _____
Phone Number: _____
Email Address: _____
Other Contact Method: _____

Information to Be Released (mark all that apply)

❏ Medical Records

❏ Therapy Evaluation

❏ Treatment Notes

❏ School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of (mark all that apply)

❏ Coordinating care with other professionals

❏ Providing continuity of services

❏ Updating therapeutic progress

By signing below:

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

❏ I understand that this authorization will remain valid until written revocation of this authorization is presented.

Signature _____ Date _____

Lifeline Speech Therapy LLC
Jaclyn Thompson, M.A., CCC-SLP
jaclynthompson@lifelinespeechtherapy.com
phone: 260.267.0259