Authorization of Medical Information

Patient Name: _____ **Date of Birth**_____

_____ **Primary Care Physician**
_____ **Occupational Therapist** _____ **Physical Therapist** _____ **Speech Therapist**

Name_____
Clinic _____
Phone #/Email_____

If applicable, please list other clinicians that you would like your therapist(s) to be in communication with:

_____ **Counselor** _____ **Developmental Optometrist** _____ **Audiologist**
_____ **Educational Providers (teachers, school, tutor)** _____ **Psychologist**

Name_____
Clinic_____
Phone # /Email_____

For the Purpose of:
___Coordinating Care with other professionals.
___Providing continuity of Services
___Updating therapeutic progress.

___ Amanda Sepe, CCC-SLP may communicate via email, fax, phone call, written report/notes, in-person meeting with my child's other providers. I understand that standard communication is not secure and can potentially be intercepted and read by unauthorized individuals.

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

By signing this form, I authorize Amanda Sepe, CCC-SLP, LLC to exchange health information with the providers listed above. This agreement will remain in effect until either parties give written notice of any changes.

_____ _____
Signature of Parent/Guardian Print Name of Parent/Guardian

_____ _____
Relationship to Client Date