**Super Speech Solutions, LLC**
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**877-544-7659**

## Authorization to Exchange, Obtain or Release Information

Client Name: _____Date of Birth: _____

Home Address: _____

_____

I _____ (client or family member) hereby grant Super Speech Solutions, 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.

_____Date_____
Print Name of Client

_____ _____
Signature of Client or Legal Representative Relationship to Client