CONSENT TO EXCHANGE INFORMATION

Patient's Name: _____

Date of Birth: _____

Telephone: _____

I hereby give my consent for Rainier Speech Therapy, LLC to send and receive information with: (Name and Individual; for example: Referring Physician, Family Member, Spouse or other Guardian, Educator or Agency)

Name	Relation to patient

Information exchanged may include but is not limited to speech/language and hearing records, medical reports, academic information and program planning. Information may be shared through written reports, by phone, fax or in person. All of the information I hereby authorize to be exchanged with the above, will be held strictly confidential and cannot be released without my written consent. I understand that I have the right to inspect and copy the information to be disclosed. I understand that I may withdraw this authorization at any time. This request is effective up to and including one (1) year from the date of signature.

_____

Patient Printed Name

_____ _____

Patient Signature Date

_____ _____ _____

Signature of Consenting Party Relationship to Patient Date