



Ideal Speech

Orange Park, Florida
oakleafspeech@gmail.com
(904)385-3304

Authorization to Exchange, Obtain or Release Information

Client Name: _____ Date of Birth: _____

Home Address: _____

For the reasons identified in this form, I _____
(client or family member) hereby grant Ideal Speech permission to
communicate (exchange, obtain, or release) my medical information with
the following person or agency:

Name of Person or Agency: _____

Person/Agency 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 this authorization will remain valid until written revocation of this authorization is presented.

Print Name of Client

Date

Signature of Participant or Legal Representative

Relationship to Client

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