Heart to Heart, LLC
SPEECH THERAPY

Release of Information

Client:_____ DOB:_____
Legal Guardian: _____

I, _____, authorize the exchange of information and documentation relating to me/my child to/from the following entities. This information will be used for professional purposes only and will not be divulged to any outside sources without written permission. This notice also authorizes the exchange of information and documentation between providers at Heart to Heart Speech Therapy pertaining to my/my child's evaluations and treatment.

Primary Care Physician:

Name: _____

Address: _____

_____

Phone: _____

Others (e.g. preschools, therapists, etc.):

Name: _____

Address: _____

_____

Phone: _____

Name: _____

Address: _____

_____

Phone: _____

Name: _____

Address: _____

_____

Phone: _____

Parent/Guardian Signature: _____

Date: _____