Speech-Language Pathology Services, LLC | 1012 Marquez Place, Suite 211 Santa Fe, NM 87505 | 505.302.0095

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 Rise 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