SMALL TALK
pediatric speech therapy

EXCHANGE OF INFORMATION

For the reasons identified in this form, I _____ the parent/legal guardian of _____, hereby grant Small Talk Pediatric Speech Therapy, LLC permission to communicate (exchange, obtain, or release) my medical information with the following professionals for the purpose of coordinating care, providing continuity of services, and updating therapeutic progress:

- ❑ Pediatrician (i.e. Medical History) _____
  _____
- ❑ Specialists (i.e. OT, ABA therapists, neuropsychological records, etc.)
  _____
- ❑ School (i.e. Evaluations, IEPs, etc.) _____
  _____

I grant permission for the exchange of information between professional via written, 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 and DOB Date

_____ _____
Signature of Client or Legal Representative Relationship to Client