Consent for Release/Exchange of Confidential Information

Date:______________________________

Child's Name:____ DOB:______________________________

Address:____City/State:______________________Zip:____________

This consent authorizes the following agency to release and exchange confidential information about this child to/from Bauer Speech-Language Therapy, LLC or Jennifer Bauer, MA, CCC-SLP.

Agency Name:____

Agency Dept:____

Contact Person:____

Address:____

City/State/Zip:____

Phone:____

Fax:____

Email:____

Checked records below are requested to be released and/or exchanged between Bauer Speech-Language Therapy, LLC or Jennifer Bauer, MA, CCC-SLP and the above agency.

- ☐ Speech-Language Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Medical/Health History
- ☐ Other:____
- ☐ Educational
- ☐ Audiometric
- ☐ Psychiatric/Psychological Records

The information requested will be used in compliance with HIPPA laws. No additional information will be released or exchanged without prior approval from the parent/guardian, except as provided by law.

☐ YES ☐ NO I consent to the release and/or exchange of the above information.

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Parent/Guardian Signature Date