Bauer
STUTTERING & SPEECH
THERAPY, LLC

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 Stuttering & Speech 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 Stuttering & Speech Therapy, LLC or Jennifer Bauer, MA, CCC-SLP and the above agency.

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

The information requested will be used in compliance with HIPAA 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.

_____

Parent/Guardian Signature Date

Bauer Stuttering & Speech Therapy, LLC
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www.bauertherapy.com