Consent for Exchange of Information

Please provide names/contact information of other professionals working with your child:

|  |  |  |
| --- | --- | --- |
| I hereby authorize the  mutual exchange of information between Pediatric Speech & Language Therapy INC and: | 1. |  |
|  | 2. |  |
|  | 3. |  |
|  | 4. |  |
|  | 5. |  |
|  |  |  |

I also give my permission for my therapist at Pediatric Speech & Language Therapy, INC to consult with other employed pediatric speech therapists who work at Pediatric Speech and Language Therapy, INC regarding treatment of my child, during the course of his/her treatment. This may include first hand observations during his/her speech sessions.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Parent |  | Date |  |

Parent’s Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name and Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_