Cooper
Therapy Connections PLLC
Speech and Language Therapy, Feeding Therapy, Counseling, Occupational Therapy, Tutoring
(779) 234-8997

Authorization to Exchange, Obtain or Release Information

Client Name: _____ Date of Birth: _____

I _____ (client or family member) hereby grant Cooper Therapy Connections permission to communicate with the following person or agency:
Name:

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 unless revoked, this authorization will remain valid until written revocation of this authorization is presented.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client or Legal Representative Relationship to Client