Collier Language and Literacy Therapy
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Authorization to Exchange, Obtain, or Release Information

Client Name: _____ Date of Birth: _____

I _____ (client or parent/guardian) hereby grant Collier Language and Literacy Therapy permission to communicate with the following person or agency to exchange, obtain, or release information. **This information includes, and is not limited to, medical records, evaluation reports, therapy notes, academic records, counseling information, and other pertinent information used solely for the facilitation of services rendered to the above-named individual.**

Name:_____
Title: _____
Contact Information: _____
_____

Name:_____
Title: _____
Contact Information: _____
_____

Name:_____
Title: _____
Contact Information: _____
_____

☐ **I grant permission to exchange information via written and mailed report, phone call, meeting, email, and/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