ATLANTA READING &
LANGUAGE THERAPY
LEARN. GROW. THRIVE.

Authorization to Exchange, Obtain or Release Information

Client Name: ___________________________ Date of Birth: _________________

I ___________________________________ (client or family member) hereby grant Atlanta Reading & Language Therapy permission to communicate with the following person or agency:

Contact Information:
Name: ____
Phone: ____
Email: ____
Address: ____
____

Information to Be Released:
☐ Medical History
☐ Therapy Evaluation
☐ Treatment Notes
☐ School Records (Evaluations, IEP, academic reports, etc.)
☐ 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