Lasting Language LLC
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Authorization to Exchange, Obtain or Release Information

Client Name: ___________________________ Date of Birth: ______________

Home Address: ____

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I ____________________________ (client or family member) hereby grant Lasting Language LLC 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 legal guardian Relationship to client

☐ I agree that my electronic signature is the legal equivalent to my handwritten signature.