AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Child's Name: ____Date of Birth: ___________

I, (fill in name) ______________________________________

(relationship to child) __________________________________

Give my consent for an exchange of information and records between Wheels of Wellness and the following individuals/organizations:

Name of individual/organization: ____
Email address: ____
Address:____Phone: _________________

Name of individual/organization: ____
Email address: ____
Address:____Phone: _________________

Name of individual/organization: ____
Email address: ____
Address:____Phone: _________________

This release shall be limited to the following specific information (mark all that apply):

- ○ Diagnosis
- ○ Results of psychological, speech/language, occupation therapy or education testing
- ○ Behavioral reports
- ○ Intervention treatment plan and progress (speech/language, occupational, behavioral therapies)
- ○ School of social group observation
- ○ Other:____

____

Parent/Guardian signature **Date**

____

Parent/Guardian signature **Date**