



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:** _____

Please do not share any of the following (please check boxes for information you request not to share)

- 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**