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**