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 Sasha Torres, M.A., BCBA 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: _____

The specific information that should be disclosed is (please check boxes for information you request to share):

- ☐ Diagnosis
- ☐ Results of medical, educational, speech/language, occupation therapy and/or psycho logical assessment/testing
- ☐ Behavioral reports
- ☐ Intervention treatment plans and progress reports (speech/language, occupational, behavioral therapies)
- ☐ Individualized Education Plan (IEP)
- ☐ Social or social skill group observation
- ☐ Other: _____

_____

Parent/Guardian Signature **Date**

_____

Parent/Guardian Signature **Date**