



**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 psychological 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**