KARE 2 COMMUNICATE

Authorization to Exchange, Obtain or Release Information

Client Name: _____ Date of Birth: _____
Home Address: _____
_____

For the reasons identified in this form, I _____ (client or family member) hereby grant KARE 2 COMMUNICATE permission to communicate (exchange, obtain, or release) my medical information with the following person or agency:

Name of Person or Agency: _____

Person/Agency Contact Information: _____

Information to Be Released:
☐Medical History
☐Therapy Evaluation
☐SLP ☐OT ☐PT ☐Other: _____
☐Treatment Notes
☐SLP ☐OT ☐PT ☐Other: _____
☐School Records (Evaluations, IEP, academic reports, etc.)

For the Purpose Of: (check all that apply)
☐Coordinating care with other professionals
☐Providing continuity of services
☐Updating therapeutic progress
☐Other _____
☐ grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.
☐ understand that this authorization will remain valid until written revocation of this authorization is presented.

_____ _____
Print Name of Client Date

_____ _____
Signature of Participant or Legal Representative Relationship to Client

5408 Beaumont Dr. Durham NC ◆ P: (919) 358-2185 ◆ F: (919) 493-1974 ◆
teresa@kare2communicate.com

5408 Beaumont Dr. Durham NC ◆ P: (919) 358-2185 ◆ F: (919) 493-1974 ◆
teresa@kare2communicate.com