Gorge Falls Therapy SLP, OT, PLLC

RELEASE OF INFOMRATION/EXCHANGE OF COMMUNCIATION

I _____(Name and relationship to client) give permission for therapists providing services at **Gorge Falls Therapy SLP, OT, PLLC** to discuss and/or share services or records in regards to

_____(client name).

The records to be shared include:
_____
_____
_____

I authorize this communication to with the following persons/providers/doctors/agency:

_____

Name	Address	phone
Name	Address	phone
Name	Address	phone

For the purpose of (check those that apply)

___updating progress
___coordination of care
___Continuity of Services
___other: _____

This agreement remains in effect or valid until a change is submitted in writing.

Signature Date