Laura Deer, M.S. CCC/SLP, CAS #16418

Licensed Speech-Language Pathologist
Certified Autism Specialist
Special Needs Certified

DEER SPEECH THERAPY

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Authorization of Release of Information

Completion of this form will serve as written permission for Deer Speech Therapy to communicate with the individual(s) you listed below for reasons as specified below.

I authorize release of information by Laura Deer, M.S. CCC/SLP, CAS to communicate with:

Name of Person / Organization: _____
Phone number: _____
e-mail address: _____

Information may be shared for the purpose of:

☐ ALL INFORMATION MAY BE SHARED – coordinating services, therapy techniques/strategies, behavioral observations, scheduling, progress reports/goals, etc.

☐ Restricted information – Do NOT share the following information: _____
_____

Communication may occur in a variety of ways (in person, text, phone conversation, e-mail, fax, etc) and may include information from the patient's medical record. E-mails containing personal information will be encrypted. You have the right to restrict how medical information is shared.

☐ NO RESTRICTIONS
☐ Only share information in the following ways: _____

Communication is authorized until:
☐ Therapy is discontinued with Laura Deer, M.S. CCC/SLP.
☐ Ends on specific date: _____

Name of child / client: _____
Child/ Client's birthday: _____
Name of parent(s) / guardian(s): _____
Date: _____

_____ _____
Signature Date signed