Consent for Interprofessional Communication

I hereby authorize Global Speech Therapy, LLC to communicate and share relevant information regarding the evaluation, treatment, and progress of:

Child's Name: _____

Specific Person(s) Authorized to Share or Receive Information:

Name(s): _____

Purpose of Communication
This authorization allows coordination of care with professionals involved in my child's development and well-being.
Professionals Authorized
Speech-language pathologists, physicians or medical providers, occupational therapists, physical therapists, psychologists or counselors, teachers or school staff, and other professionals involved in my child's care.
Information That May Be Shared
Evaluation reports, treatment plans and goals, progress updates, recommendations, and attendance or scheduling information.
Methods of Communication
Information may be shared in person, by phone, written reports, secure email or electronic records, fax, or secure telehealth platforms.
Confidentiality
All information will be shared only as necessary and in accordance with applicable federal and state privacy laws, including HIPAA.

This consent remains in effect □ for the duration of services or □ until _____

Signature: _____ Date: _____

Name:_____

Relationship to client: _____