

Double Talk – Bilingual Speech Therapy Services

Krista Hammer, MS, CCC-SLP

240 Redtail Road, Suite 12 A

Orchard Park, NY 14127

hammerdoubletalk@gmail.com

(716) 608-2988 ofc. / (716) 608-2942

Authorization to Exchange, Obtain

or Release Information

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (client or family member) hereby grant [Double Talk / Krista Hammer] permission to communicate with the following person or agency:

Name:

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ I grant permission to exchange information via written and mailed report, phone call, meeting, email, or fax.

☐ I understand that unless revoked, this authorization will remain valid until written revocation of this authorization is presented.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Legal Representative Relationship to Client

Authorization to Exchange, Obtain or Release Information