WORD OF MOUTH
Clinical Associates

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

(Please fill out form in its entirety)

We the parents of _____ do hereby give permission to:

(School)_____ _____

(Physician)_____

(Other)_____

(Other)_____

to furnish Word of Mouth Clinical Associates with any information requested for the assessment and or/treatment of our child.

We by this same instrument give our permission to Word of Mouth Clinical Associates to furnish:

(School)_____

(Physician)_____

(Other)_____

(Other)_____

an oral or written report of the testing, plan of treatment, and recommendations made for our child.

Please initial one of the following statements:

_____ I grant permission for my child's clinician and teacher(s) to communicate directly with one another regarding treatment goals, progress, and identified needs.

_____ I do not grant permission for my child's clinician and teacher(s) to communicate directly with one another regarding treatment goals, progress, and identified needs.

I understand that I may revoke this consent to release protected health information at any time, by written request.

Parent Signature: _____ Date: _____