MEGGAN LEVSON
Speech-Language Pathologist
Helping Children Talk...

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CONSENT TO EXCHANGE INFORMATION

Child's Name: _____

Date of Birth: _____

I agree that my child's personal health information consisting of (describe personal health information to be disclosed):

_____

may be disclosed between Meggan Levson, Speech-Language Pathologist and other service providers/agencies indicated below, for the purpose of facilitating my child's speech and/or language development:

Child Care: _____

Hospital Clinic: _____

Doctor: _____

School (name & board): _____

Speech & Language Provider: _____

Other: _____

I understand that consent to exchange information is valid for one year from the date consent was issued. I also understand that I can refuse to sign this consent form and I that may withdraw consent to exchange information at any time.

Name of Parent/Guardian: _____

Address: _____

Phone Number: _____

Signature: _____

Date: _____