Kay Armstead Center for Communicative Disorders
Dept. of Communicative Disorders and Sciences · Connie L. Lurie College of Education
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EXCHANGE OF INFORMATION

CLIENT INFORMATION

Name: _____ Birthdate: _____
First M.I. Last M/D/Y

Preferred Phone: (____) _____ Other Phone:(____) _____

Email: _____

I hereby authorize the Kay Armstead Center for Communicative Disorders to exchange information with the following individuals or agencies for the purposes of speech, language and hearing diagnostics and treatment.

AUTHORIZED EXCHANGE*

Initial for Consent to: ☐ request information _____ ☐ Release information _____ with:
(initial) (initial)

Name: _____ Title: _____

Phone: (____) _____ Email: _____

Address: _____
Street city state zip

Type and amount of information (initial for consent):

_____ verbal exchange _____ written exchange
_____ complete health records _____ lab/x-ray results
_____ complete therapy records (treatment plans/reports/evaluations)
_____ other (please specify): _____

Initial for Consent to: ☐ request information _____ ☐ Release information _____
(initial) (initial)

Name: _____ Title: _____

Phone: (____) _____ Email: _____

Address: _____
Street city state zip

Type and amount of information (initial for consent):

_____ verbal exchange _____ written exchange
_____ complete health records _____ lab/x-ray results
_____ complete therapy records (treatment plans/reports/evaluations)
_____ other (please specify): _____

_____ _____ _____
Client/Caregiver Name (print) **Client/Caregiver Signature** **Date***

*Valid for one year from date signed but may be revoked any time prior in writing.

Effective 12/15/17