Communication Cottage Therapy LLC
5000 Highway 17 Bypass South
Myrtle Beach SC 29588
PHONE: (843) 318-9207
FAX: (843) 582-0259

Authorization to Exchange and Release Information
Communication Cottage Therapy, LLC

Client Name: _____ **Date of Birth: _____**

Home Address: _____

I _____ (legal guardian) hereby grant Communication Cottage Therapy LLC, permission to communicate with the following person(s) for the purpose of sending therapy updates and coordinating care.

Please include the facility name and people Communication Cottage Therapy is allowed to speak with regarding your child's care as well as their contact information if applicable/known

Payor/Insurance: _____

Doctor: Name(s): _____ Practice Location: _____

Specialists: Name(s): _____ Specialty: (e.g., ENT, GI, Neuro)_____

Location: _____ Contact: _____

Daycare: _____ Teachers_____ Address:_____

Early Intervention: Company: _____ Name of EI/Service Coordinator:_____

Phone: _____ Email:_____

School: Name: _____ Teachers/Related Specialists (OT/SLP/Psych): _____

Please list contact information for those involved in your child's care for therapists to coordinate care if known: (name + email + phone number)

_____

_____

_____

_____

Additional Caregivers (not legal guardians)_____

Other Contacts that can be informed about my child's care (if applicable):

Name: _____ Phone: _____ Email:_____

Communication Cottage Therapy LLC
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Information That May Be Released:

□ Medical History

□ Therapy Evaluation/Re-Evaluation □ SLP □ OT □ PT □ Other: _____

□ Treatment Notes/Care Plan □ SLP □ OT □ PT □ Other: _____

□ School Records (Evaluations, IEP, academic reports, etc.)

I _____, grant permission to exchange information via in person conversation, 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	**Signature of Legal Guardian/Printed Name of Guardian**	**Date of Form Completion**