**Olepeka SLP Services**
www.olepekaslp.com

# Authorization to Release/Obtain Information Form

I (parent or guardian) consent that Olepeka SLP Services, may release or obtain **confidential information and/or records** regarding my child in order to assist with services provided in the best interest of the child. This consent includes having the SLP work directly with my child at school or daycare when I am not present.

Child's Full Name: _____

Child's Date of Birth: _____

Parent or Guardian Name(s) _____

Relationship to child:_____

Address: _____

Phone number: _____

email:_____

Today's Date: _____

Parent or Guardian Signature: _____

Please check all applicable boxes and list specific individual and organization:

- ☐ School District (name of district &/or school): _____
- ☐ Health & Social Services (eg. OT, SLP, CDT, Pediatrician, Health Authority, SW):

  _____

  _____
- ☐ Other (eg. Counsellor, specialist, Individual, etc.): _____
- ☐ _____

- ✓ I understand I can choose who I give consent to obtain/share information with, and I can ask questions about consent at any time.
- ✓ I understand that I can withdraw consent to share information with any individual at any time if I choose.
- ✓ I understand that by law there are situations in which disclosure of information is mandatory.

_____