maui SPEECH and SWALLOW
NEUROLOGICAL REHABILITATION, LLC
**Email: admin@mauispeechandswallow.com**
**Phone: (808) 856-9821 Fax: (808) 856-0115**

# Authorization to Exchange, Obtain or Release Information

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

**I _____ (client or family member) hereby grant 'Opio Makamae/Maui Speech and Swallow permission to communicate with the following person or agency:**

**Name:**
**Contact Information:**

**Information to Be Released:**
☐ Therapy Evaluation
☐ SLP ☐ OT ☐ PT ☐ Other: _____
☐ Treatment Notes
☐ SLP ☐ OT ☐ PT ☐ Other: _____
☐ School Records (Evaluations, IEP, academic reports, etc.)

**For the Purpose Of: (check all that apply)**
☐ Coordinating care with other professionals
☐ Providing continuity of services
☐ Updating therapeutic progress
☐ Other _____

**☐ I grant permission to exchange information via written and mailed report, 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 Date

_____ _____
Signature of Client or Legal Representative Relationship to Client