

PERMISSION FOR MUTUAL EXCHANGE OF INFORMATION

pathways to communication tm

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Date: _____

Permission is granted to mutually exchange information pertaining to therapy services being provided to my child:

Child Name: _____ *Date of Birth:* _____

Parents Names: _____

This permission is granted between pathways to communication staff and:

(Please complete a separate form for separate outside providers)

Permission is granted for mutual exchange using the following methods (check all that apply):

- Phone* *Phone number of outside provider if available:* _____
- Fax*
- E mail*
- in person*

This mutual exchange will remain in effect until notified that consent is discontinued

Authorized Signature

Print Name

Thank You!

