613 Cook St
Royston, GA 30662
Phone: (706) 491-5409
Fax: (888) 234-6659

Authorization to Exchange, Obtain or Release Information

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

I _____ (client or family member) hereby grant Shining Star Therapy Services, LLC permission to communicate with the following person or agency:

Name:

Contact Information:

Information to Be Released:
□ Medical History
□ Therapy Evaluation
□ Treatment Notes
□ 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