info@sparkandthrivetherapy.com 516-204-2388 @SparkAndThriveTherapy

CONSENT OF INFORMATION

Authorization is hereby granted to the _____ to release information to

Name of school, physician, agency, individual

Eri SLP PLLC DBA Spark and Thrive Therapy via e-mail at info@sparkandthrivetherapy.com for the

following information pertaining to _____.

Name of client

TO BE RELEASED (check all that apply):

_____ Evaluation Reports

_____ Individualized Education Programs (IEPs)

_____ Psychological Reports

_____ Psychiatric Reports

_____ Health and Medical Records/Information

_____ Permanent Records (name, address, birth date, grade levels, grades, class standing, attendance, standardized achievement, ability, aptitude test scores, etc.)

_____ School Observations, Functional Behavior Assessments (FBAs), Rating Scores

_____ Verbal, Written, and/or Electronic Communication including completion of intake forms

_____ _____

Parent/Guardian Signature (for clients under 18 years of age) Date (mm/dd/yyyy)

_____ _____

Client Signature (for clients 18 years of age or older) Date (mm/dd/yyyy)