710 NW Juniper St., Suite 100
Issaquah, WA 98027
Tel: 425.369.4702 | Fax: 425.369.4707
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EXCHANGE OF INFORMATION AUTHORIZATION

Patient's Name: ________________________________

Patient's Date of Birth: ___________________________

It is important to communicate with your other providers so we can all work together in your best interest. Examples of other providers may include:

Physical Therapist   Occupational Therapist   Speech Therapist   ABA Therapist

Neurologist   Psychologist   Educational Providers (teachers, school)   Counselor

Name and Clinic	Address	Phone/Email	Date

_____I do not authorize Eastside Occupational Therapy to exchange medical information with any of the other providers.
_____Eastside Occupational Therapy may communicate via email with any of the other providers listed. I understand email communication is not secure and can potentially be intercepted and read by unauthorized parties. Email communication will be treated with the same confidentiality as written medical records and will become part of your permanent record.
_____I opt out of email authorization.

** By signing this form I authorize Eastside Occupational Therapy to exchange health information with the providers listed above. This agreement will remain in effect until I give written notice of any changes, or upon my discharge from therapy. I understand that I may revoke this authorization at any time in writing. **

Patient Name (printed): ___________________________________

Patient Signature: ____   Date: ________________________________