EASTSIDE
OCCUPATIONAL THERAPY

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EXCHANGE OF INFORMATION AUTHORIZATION

Child's Name: _____

Child's Date of Birth: _____

It is important to communicate with your child's other providers so we can all work together in the best interest of your child. 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 child's 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 child's discharge from therapy. I understand that I may revoke this authorization at any time in writing. **

Parent/Guardian Name (printed): _____ Relationship to child: _____

Parent/Guardian Signature: _____ Date: _____