Aspire Therapies, LLC

2851 Stage Village Cove, Suite 2, Bartlett, TN 38134
Phone (901) 949-9488 · Fax (800) 420-3359

Form 9: Authorization to Exchange Information

Working with the other people in your child's life, like their doctor, teacher, or daycare, helps us coordinate care. This form lets you choose who we may share information with. Sharing with your child's referring provider and insurance company for treatment and payment does not need this form.

Child's name _____ Date of birth _____

Part A: Family members and friends

List anyone (grandparents, relatives, friends, babysitters) who may pick up your child or receive information about your child's care. Name, relationship, and phone number are required for each person. Staff may ask for photo ID at pickup.

Name (required)	Relationship (required)	Phone (required)	May pick up child?	May receive information?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Information that may be shared with these family members and friends (check all that apply):

- ☐ Appointment times and attendance
- ☐ General progress updates
- ☐ Home practice activities
- ☐ Billing and balance information
- ☐ Full therapy records

Part B: Professionals and other clinicians

I authorize Aspire Therapies, LLC to exchange information about my child with these professionals (doctors, teachers, daycare staff, other therapists and clinicians):

Person or organization	Role (doctor, school, daycare, other therapist)	Phone	Email	Share	Receive
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

Information that may be shared with professionals and other clinicians (check all that apply):

- ☐ Evaluation reports
- ☐ Plan of care and goals

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- ☐ Progress notes and updates
- ☐ Attendance
- ☐ IEP, IFSP, or 504 plan documents
- ☐ Verbal conversations about my child's care

Purpose: coordination of my child's care and education.

This authorization expires on _____

or one year from the date signed, whichever comes first.

I understand that:

1. I may revoke this authorization at any time in writing, except for information already shared.
2. Signing is voluntary. My child's treatment, payment, or eligibility for services does not depend on it.
3. Information shared with someone not covered by HIPAA (such as a daycare) may no longer be protected by federal privacy law.
4. I may receive a copy of this form.

Parent/guardian signature _____

Printed name _____ **Relationship** _____

Date _____