

Request for Exchange of Information

Please provide names/contact information of other professionals working with your child:

I hereby request the mutual exchange of communication between *Childhood Speech & Language* and:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Signature _____ Date _____

HIPAA NOTIFICATION

I am required by law to maintain the privacy of protected health information, give you a notice of our legal duties and privacy practices regarding health information about your child, and follow the terms of this notice that is in effect as of 4-14-03 (attached pages).

By signing this document you acknowledge receipt of the privacy policy as it relates to protected health information about your child's treatment, payment and health care operations. You have the right to request restrictions, which must be made in writing to Childhood Speech and Language, 2775 152nd Ave NE, Redmond, WA 98052.

Signature _____ Date _____