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Authorization for Exchange of Information

Child's name: _____

Address: _____

City, State, Zip: _____

Birth Date: _____

I give permission for the exchange of information, regarding the child listed above, between:

Time to Talk, LLC
9910 White Blossom Boulevard
Louisville, KY 40241

and the following facilities. This includes medical records, clinic notes, school records and any pertinent information that will help in developing the child's treatment program.

Facility: _____

Address: _____

City, State, Zip: _____

Phone: _____

Parent/ Guardian: _____

Address: _____

City, State, Zip: _____

Phone: _____

Signature of parent/guardian

Date

REVOCATION SECTION

I hereby revoke this authorization.

Signature of parent/guardian

Date