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Authorization for Consultation

This is an optional agreement you can sign if you would like me to be able to consult with any other professionals you have worked with. Please print/sign/photo or provide an electronic signature.

I authorize Dr. Austina De Bonte to consult with the following professionals regarding my children's educational, behavioral, or developmental needs:

Neuropsychologist(s) or Clinical Psychologist(s):

Teacher(s) or Tutor(s):

Educational Advocate(s) or Lawyer(s):

Counselor(s) or Therapist(s):

OT, Vision, Auditory, etc. Provider(s):

Other:

This authorization permits the exchange of any information you have provided to me, including assessment results, educational records, medical records, work samples, and professional recommendations, as well as sharing my own observations, notes, and recommendations. If you have limitations on which information you wish for me to discuss or share with others, please specify here:

☐ No limitations

☐ Please only share the following:

Authorization valid from _____ to _____
Date Date

_____ _____
Client Signature Date