Talk SLP LLC

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OFFICE USE ONLY	
ID	
DATE	
OTHER	

CONSENT FOR RELEASE OF INFORMATION

I, _____, hereby consent for the release of information
YOUR FULL NAME

_____ TO and/or _____ FROM the speech-language pathologists and affiliates for the coordination of evaluation and treatment services. Specifically, I consent for the following persons and/or entities to share, via all means of communication, information regarding my status in the areas of:

____ COMMUNICATION

____ BEHAVIOR

____ HEALTH/MEDICAL

____ ACADEMICS

NAME(S) OF PERSONS/ENTITIES:

_____

_____

_____

_____

By signing below, I understand that this consent will remain effective for one year from the date of signing and that I may withdraw this consent at any time.

_____ _____
YOUR SIGNATURE DATE