AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Way to Grow, LLC to share information related to my child _____ (DOB:_____), both verbally and in writing (including by email), with the professionals listed below. Please provide the following: (1) name and relationship to child (e.g., pediatrician, teacher, speech therapist); (2) address; (3) phone number; and (4) email address.

_____	_____
_____	_____
_____	_____
( ) _____	( ) _____
_____@_____	_____@_____
_____	_____
_____	_____
_____	_____
( ) _____	( ) _____
_____@_____	_____@_____
_____	_____
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( ) _____	( ) _____
_____@_____	_____@_____
_____	_____
_____	_____
_____	_____
( ) _____	( ) _____
_____@_____	_____@_____

_____	_____
Name of parent/guardian (please print)	Signature of parent/guardian
_____	_____
Relationship to child	Date