Authorization for Release of Information

Client's Name: ____________________________________ DOB:___________________

I,____(client or legal guardian), hereby authorizes Therapy and Learning Center of GA to ☐ SEND and/or ☐ RECEIVE information ☐ TO and/or ☐ FROM: Name of Person or Facility: __________________________________

Address:____

____ Phone: ____________________

Educational Evaluation Results

Behavior Intervention Plan

School Records

Psychological Reports

Audiological Report

Psychological Testing Results

Occupational/Physical Therapy Reports

Medical Records

Entire Record

Speech and Language Evaluation/Progress notes

Other (specify):

____

The above information will be used for the following purposes:

- Planning Treatment of Program
- Determining Eligibility for Benefits or Program
- Updating Files
- Other (specify): ____

1. I understand that authorization is voluntary and I may revoke consent at any time by providing written notice.
2. Authorization is valid for the length of time that the above named patient is under the care of Milton Speech Pathology.
3. I have been informed what information will be given, its purposes and who will receive the information.
4. I understand that I have a right to receive a signed copy of this authorization. I understand that I have the right to refuse to sign this authorization.

____
Signature of Parent or Legal Guardian

____
Relationship to Client

____
Print Client's Name

____
Date