Clermont Speech and Language
Therapy Center,LLC
700 East Grand Highway
Clermont, FL 34711
352-432-3960
www.clermontspeechlanguage.com

# CONSENT TO EVALUATE/TREAT/RELEASE INFORMATION

Date: _____

I, _____authorize Clermont Speech and Language
**(Legal Guardian) Please Print**

Therapy Center to evaluate _____ and/ or provide Speech and/or
**(Patient Name) Please Print**
Language therapy.

I, _____ authorize Clermont Speech and Language Therapy Center
**Please Print Name**

to discuss and/or receive medical information, including medical records concerning me (adult patient) or my child _____ to and from the following persons or agencies.

| Name | Address |
|---|---|
| Name | Address |

In consideration of treatment and educational purposes, I give consent that sound recordings, records and or photographs may be used as deemed helpful by the staff. I understand that the information may be discussed with Patient's Physician regarding evaluation and or treatment goal strategies.

*This form has been fully explained to me/us and I/we understand the contents.
*I have read and received a copy of Clermont Speech and Language Therapy Center, LLC "Notice of Private Practices."

**(Legal Guardian or Patient Signature)** **Date**