Blossom Therapies of Florida
(727) 310-4134
blossomtherapiesfl@gmail.com

OFFICE USE ONLY	
ID	
DATE	
OTHER	

CONSENT FOR RELEASE OF INFORMATION

As the parent/guardian of _____, I hereby consent for the release of information
FULL NAME OF CHILD

_____ TO and/or _____ FROM the speech-language pathologists of Blossom Therapies of Florida and its affiliates for the coordination of services for my child. Specifically, I consent for the following persons and/or entities to consult with Blossom Therapies of Florida, via all means of communication, regarding my child's 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.

_____ _____

PARENT/GUARDIAN SIGNATURE Date