CONSENT FOR RELEASE OF INFORMATION

CLIENT: _____ PARENTS/GUARDIANS: _____
DATE OF BIRTH: _____

ASPIRE SPEECH THERAPY IS HEREBY GIVEN PERMISSION TO SEND REPORTS REGARDING EVALUATIONS AND/OR TREATMENT TO:

Primary Care Physician: _____
School: _____
_____
_____

I HEREBY GIVE PERMISSION FOR INFORMATION TO BE RELEASED TO ASPIRE SPEECH THERAPY FROM:

Primary Care Physician: _____
School: _____
_____
_____

SIGNATURE:_____ DATE: _____
RELATIONSHIP TO CLIENT: _____
WITNESS: _____

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