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RELEASE OF INFORMATION

I HEARBY AUTHORIZE CORRESPONDANCE, EITHER BY PHONE, FAX OR MAIL REGARDING:

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(PATIENT NAME & DOB)

BETWEEN SPEECH THERAPY ASSOCIATES AND THE FOLLOWING OFFICE(S) and/or PERSON(S):

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( ) History & Physical ( ) Progress Notes ( ) Radiology Report

( ) Complete Medical Records ( ) Consult Report ( ) Other:______________

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SIGNATURE

____
RELATIONSHIP

____
DATE