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AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION

Certified Member

**AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION**

I hereby authorize **Rebecca Thorsen** MS, CCC-SLP to discuss or release pertinent medical/health information from the speech pathology record of:

\_\_\_\_\_  
Client name

\_\_\_\_\_  
Date of Birth

**This information is to be released to the below named person/entity:**

\_\_\_\_\_

This information will be used for the care and treatment of the client and for no other reason(s).

\_\_\_\_\_  
Name of Parent (Please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date