STACY VARON SPEECH PATHOLOGY

Release of Information

Child:_____ DOB:_____

I hereby authorize Stacy Varon Speech Pathology to consult with entities listed below. Stacy Varon Speech Pathology is permitted to request and/or share information deemed relevant for the coordination of services including test results, treatment plans, goals, progress and clinical impressions.

Name: _____Title: _____

Organization: _____

Phone: _____ Email: _____

Address:_____

Name: _____Title: _____

Organization: _____

Phone: _____ Email: _____

Address:_____

I understand the records are protected under the federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time. I have read this consent and I understand it.

Legal Guardian Signature: _____ Date: _____

Legal Guardian Printed Name: _____

Relationship to Child: _____