SPEECH • LANGUAGE • PATHOLOGY • Center

Consent for Release of Information

Patient/Client's Name:_____

Date of Birth: _____

I, _____ authorize the release of information including, but
Parent/Guardian Name
not limited to: evaluation reports, treatment plans, progress notes and therapy documentation, as well as

necessary verbal communication pertaining to my child.

FROM:

☐ **Speech-Language Pathology Center** **99 Longwater Circle, Norwell, MA 02061** **Phone: (781) 792-2700** **Fax: (781) 792-2707**	☐ _____ **Practice/Provider Name** _____ **Street Address** _____ **City State Zip Code** **(___)_____(___)_____** **Phone Number Fax Number**

TO:

☐ _____ **Practice/Provider Name** _____ **Street Address** _____ **City State Zip Code** **(___)_____(___)_____** **Phone Number Fax Number**	☐ **Speech-Language Pathology Center** **99 Longwater Circle, Norwell, MA 02061** **Phone: (781) 792-2700** **Fax: (781) 792-2707**

This information is to be used for diagnostic and treatment planning purposes only. It is my understanding that this information will not be shared with any other entity without my prior knowledge. I further acknowledge that the use of this information is to ensure the best quality of care possible for my child. Thank you for your prompt attention in this matter.

_____ _____

Parent/Guardian Name Date

_____

Parent/Guardian Signature