

Information Release Form

I authorize Maryann P. Kaminsky, M.Ed., CCC-SLP to consult, exchange diagnostic and therapy information with the following professionals regarding:

Patient's Name Birthdate

Audiologist

Physician

School SLP

Psychologist

Occupational Therapist

Other

Signature Date

Relationship to Patient

PLEASE NOTE:

Authorization for the release of information is good for the length of time that the above named patient is under the care of In Plain English, LLC unless otherwise terminated by patient or legal guardian (requests for termination of this agreement must be made in writing).

Mail To:

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Scan and Email To:

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