

*Speech * Language * Learning*

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AUTHORIZATION FOR RELEASE AND/OR USE OF CLINICAL MATERIAL

I do hereby give consent for the evaluation and treatment of myself or my minor child _____

I further give my permission for the exchange of information regarding myself or my child with the following people:

Name:

Address:

Phone:

1) School

2) Doctors

3) Insurance

I understand that all information will be confidential and not released to any unauthorized persons.

Signature of Parent or Guardian