Speech and Language Services, Inc.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Small Talk Speech & Language Services, Inc. to release and obtain any medical and other pertinent information to and from all physicians, agencies, schools, academic and medical professionals, unless otherwise stated, for the purpose of my child's diagnosis, care and treatment. This information may include medical, psychological, educational, and/or therapy diagnostic/treatment results.

Per my initials, I **do not** authorize the above release of information to the following:

_____ _____

_____ _____

_____ _____

This authorization shall remain in force as long as my child is receiving Speech Therapy services from Small Talk Speech & Language Services, Inc.

Patient's Name: _____ DOB: _____

Parent/Guardian's Name: _____

_____ _____

Signature of Parent/Guardian Date

_____ _____

Witness Date

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