



# Communications

We teach to improve speech!

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## CONSENT FOR RELEASE OF INFORMATION

Name: \_\_\_\_\_

Date: \_\_\_\_\_

I, \_\_\_\_\_, consent for SLP  
COMMUNICATIONS OR ITS AGENTS TO PROVIDE MEDICAL  
INFORMATION ABOUT MYSELF OR MY CHILD FOR THE PURPOSES  
CHECKED BELOW:

- EDUCATIONAL
- BILLING
- OTHER \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed and Completed by:

\_\_\_\_\_  
Signature and Title Date: \_\_\_\_\_