LKN Speech Language Pathology

CONSENT FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

Date _____

I give Marianne Umphlett, Speech Language Pathologist permission to evaluate and/or provide therapy services to my child.

Parent signature _____

I give Marianne Umphlett permission to release my child's speech and language information to the following that are deemed pertinent and appropriate in the medical and educational care of my child. This information may include evaluation reports, treatment plans, progress summaries, phone conversations and emails.

This information may be shared with:

1. _____

2. _____

3. _____

4. _____

5. _____

Parent signature _____

Print signature _____

Child's name _____

Child's date of birth _____

Today's date _____

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