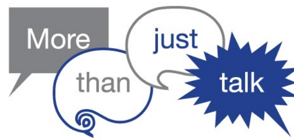

CONSENT FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION 2023

DATE: ________________

I give LKN Speech-Language Pathology and the Speech Language Pathologist team: Marianne Umphlett, Amy Elder, Kaitlyn Kimrey, Diane Drakulic, Marissa Larkin and/or Emily Mahar permission to evaluate and/or provide therapy services for:

____.

______________________________________Signature

I give LKN Speech Language Pathology permission to release pertinent information to the following people listed below that are deemed appropriate in my therapy plan of care/medical/educational care. This information may include evaluation reports, treatment plans, progress summaries, phone conversations, text messages, and emails. This is for collaboration and continuity of care among the involved parties.

This information may be shared with:

1. **_________________________ (Parents)**
2. **_________________________ (Doctor)**
3. **_________________________ (Psychologist)**
4. **_________________________ (Teacher)**
5. **_________________________ (Additional therapy Providers)**

You have my permission to send information regarding my child by ___ text, ____ email, ____ phone calls. (Check all that apply)

______________________Signature _____Date __________________ Preferred Phone

______________________ Printed Name ____Date __________________ Preferred email

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Mailing Address | P.O. Box 572 | Davidson, NC 28036 PHONE 704-641-0338 **LKN-SLP.com**