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AUTHORIZATION FOR RELEASE OF MEDICAL/HEALTH INFORMATION

I hereby authorize **Rebecca Thorsen** MS, CCC-SLP to discuss or release pertinent medical/health information from the speech pathology record of:

_____
Client name

_____
Date of Birth

This information is to be released to the below named person/entity:

_____

This information will be used for the care and treatment of the client and for no other reason(s).

_____
Name of Parent (Please print)

_____
Signature

_____
Date