The Speech Path
Your PATH to success starts here.

Occupational Therapy
Physical Therapy
Speech Therapy

Release of Information

I, _____ (Please Print Name), authorize The Speech Path, LLC to release and obtain clinical information regarding:

_____(Patient's Name),

_____ Medical Information – Diagnosis, Onset, Treatment Regimen

_____ School Documentation/IEP/FIE/Attendance

_____ Physician notes related to Speech/Language/Hearing/Cognition

_____ Psychiatric Evaluation/Treatment Information

_____ Physician notes related to fine motor, mobility, sensory awareness, and ADL's

_____ Other_____

To and from the following persons or agencies:

_____

Name Address Phone Number Fax Number

_____

Name Address Phone Number Fax Number

_____

Name Address Phone Number Fax Number

In consideration of treatment and educational purposes, I give consent that sound recordings, records, and/or photographs may be used as deemed helpful by the staff.

This form has been fully explained to me/us and I/we understand the contents.

_____

Name Date Relationship to the Client

_____

Witness Date Position

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