



Milton Speech Pathology

Speech • Language • Literacy • Social Thinking®

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____ DOB: _____

I, _____ (client or legal guardian), hereby authorizes

Milton Speech pathology to SEND and/or RECEIVE information TO and/or FROM:

Name of Person or Facility: _____ Phone: _____

Address: _____

Educational Evaluation Results

Behavior Intervention Plan

School Records

Psychological Reports

Audiological Report

Psychological Testing Results

Occupational/Physical Therapy Reports

Medical Reports

Entire Record

Speech and Language Evaluation/Progress notes

Other (specify):

The above information will be used for the following purposes:

Planning Treatment of Program

Determining Eligibility for Benefits or Program

Updating Files

Other (specify):

1. I understand that authorization is voluntary and I may revoke consent at any time by providing written notice.
2. Authorization is valid for the length of time that the aboved named patient is under the care of Milton Speech Pathology.
3. I have been informed what information will be given, its purposes and who will receive the information.
4. I understand that I have a right to receive a signed copy of this authorization. I understand that I have the right to refuse to sign this authorization.

Signature of Parent or Legal Guardian

Relationship to Client

Print Client's Name

Date