Wake Pediatric Speech Therapy

CARY office:
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Contact Information:
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(F) 919-882-8110

CLAYTON office:
9933 U.S. 70 Bus. Hwy W.
Clayton, NC 27520

CONSENT FOR SERVICES AND EXCHANGE OF INFORMATION

I hereby grant Wake Pediatric Speech Therapy, PLLC permission to provide services to my child, which may include a speech and language screening, evaluation, and/or therapy.

I also authorize Wake Pediatric Speech Therapy, PLLC to release information in my child's record, including evaluation results, goals, therapy notes, or progress notes to:

- ☐ My child's pediatrician: _____
- ☐ My child's school / preschool: _____
- ☐ The CDSA
- ☐ Other: _____

The purpose of any exchange will be to coordinate patient care.

I understand that this consent is voluntary and that I may revoke this consent in writing at any time.

_____ _____

Patient Name Date of Birth

_____ _____

Parent / Guardian Name Date