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 Client or Legal Guardian Relationship to Client

_____ _____
Print Client's Name Date