



**Children's Speech and
Language Services, LLC**

Authorization for Release of Information

Name of Client: _____

I give permission for Children's Speech and Language Services, LLC to exchange information about my child's evaluation, treatment, and/or progress with the person/facility listed below for the purpose of collaborating on my child's case. I understand that communication between Children's Speech and Language Services, LLC and the person/facility named below may occur via phone, in-person conference, fax, postal exchange, and/or e-mail.

Name of Person/Facility: _____

Street Address: _____

City/State/Zipcode: _____

Phone Number: _____

E-mail Address: _____

I understand that this authorization will expire 3 months after my child is discharged from the care of Children's Speech and Language Services, LLC. I have the right to cancel this authorization at any time by submitting a written notice of cancellation to Children's Speech and Language Services, LLC. Cancelling an authorization does not change any release that occurred before the cancellation. I may request a copy of this signed authorization at any time.

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Date Signed: _____