Shoreline
Speech & Language Center

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RELEASE OF INFORMATION

I, _____, _____, hereby give consent to the therapists
Your name relationship to child

at Shoreline Speech & Language Center to release information concerning the evaluation,

treatment and care of _____ D.O.B. _____.
minor's name

to _____
Physician's name
_____
Physician's address
_____
Physician's phone number

to _____
name
_____
profession
_____
email phone

to _____
name
_____
profession
_____
email phone

_____
Signature of Parent, Guardian, or Authorized Agent Date