PENINSULA ASSOCIATES
SPEECH THERAPY SERVICES

# RELEASE OF INFORMATION

I authorize PENINSULA ASSOCIATES SPEECH THERAPY SERVICES to exchange (receive and send) information regarding:

Client's Name: _____ Date of Birth: _____

With the following agency and/or individual:

[**People to list**: Medical Professionals who referred you to us, schoolteachers/therapists that would need updates regarding progress OR simply write "N/A" and sign below]

1. NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

Relationship to Client:_____

2. NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

Relationship to Client:_____

3. NAME: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

Relationship to Client:_____

_____ Date:_____

SIGNATURE of Client's Parent/Guardian:

_____

Print name