DISCOVERING EXPRESSION
SPEECH & LANGUAGE

CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Child's Name:_____

Birthdate:_____Address:_____

City:_____Zip:_____Parent/Guardian:_____

Relationship to child:_____

By signing below, I grant my permission for the release and exchange of information pertaining to my child's medical, physical, educational and social/emotional condition and treatment between Discovering Expression speech & Language and the following parties. I understand that I may revoke this consent at any time by giving notification in writing, except to the extent that action has been taken in reliance on it.

Information may be exchanged between:

Discovering Expression Speech & Language

3231 Willamette Dr. NE Suite C Lacey WA. 98516

Phone 360-489-6485 Fax 844-452-1758

heather@discoveringexpression.com

Name ***Address*** ***phone #***

Physician: _____

School District:_____

Other therapist:_____

Other specialists _____

Parent/Guardian Signature Date

_____