



CONSENT FOR RELEASE OF INFORMATION

My signature below will constitute my consent for the release and exchange of pertinent educational, medical / audiological, and psychological records relative to my child:

_____, birthdate _____

between Claire Norton's Speech-Language and Learning Services at Coastside Pediatric Therapy Center

and _____

primary care physician _____

Address: _____

Telephone: _____

I understand that the records released will be kept confidential by the receiving person or agency and used for professional purposes disclosed to me.

I further understand that as parent or legal guardian I have the right to review my child's records and to withhold any records that I do not wish to be forwarded to the above person or agency.

Signature of Parent / Guardian

Date

Address

City, State, Zip Code

Home Phone

