NW Speech Therapy, LLC.
Building Better Ways to Communicate

Information Release Form

I authorize NW Speech Therapy to communicate with my insurance, primary care facility or any other agency that is affiliated with my child. This may include therapy reports, EI records, school reports, medical records, email and telephone contact. I understand that this is voluntary and I may refuse to sign without it affecting my child's treatment. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization. I may revoke this authorization at any time, in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

Child's Name:____________________________________ DOB:________________

Orthodontist __________________________
Dentist ______________________________
Physician ____________________________
Allergist _____________________________
ENT _________________________________
Audiologist___________________________
School SLP __________________________
OTHER: _____________________________
OTHER: _____________________________

Signature: ____
Date: ___________

Relationship to patient:___________________________________

PLEASE NOTE: Authorization for the Release of information is good for the length of time that the above named patient is under the care of NW Speech Therapy unless otherwise terminated by patient or legal guardian. Requests for termination of this agreement must be made in writing.