

Information Release Form:

I authorize Jennifer Getch, MA. CCC-SLP to consult, exchange diagnostic and therapy information with the following professionals regarding:

Client's Name: _____

DOB: _____

Orthodontist _____

Dentist _____

Physician _____

Allergist _____

ENT _____

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).