Cobblestone
Speech, Language & Learning

Consent for Release/Exchange of Information

I, _____

Parent/Legal Guardian of _____ DOB: _____

hereby authorize Cobblestone Speech, Language and Learning to:

□ Release confidential records
□ Obtain confidential records
□ Electronically/Verbally communicate with_____
□ Other, please specify: _____

_____

Please provide names/contact information, including fax number of other professionals working with your child):

1. _____

   _____

2. _____

   _____

3. _____

   _____

4. _____

   _____

I also give my permission for my therapist at Cobblestone Speech, Language and Learning to consult with other employed pediatric speech therapists who work at Cobblestone Speech, Language and Learning regarding treatment of my child, during the course of his/her treatment. This may include first hand observations during his/her speech sessions.

Signature: _____ Date: _____