Authorization for Release of Information

While sessions are confidential, signing this form allows your clinician to collaborate with anyone who has been listed by you, the parent(s)/guardian(s).

Do not list parent(s)/legal guardian(s) of the child (i.e., mom and/or dad). Please list anyone you are granting permission for Chesapeake Speech Language Associates, LLC to communicate your child's treatment with including but not limited to, loved one/nannies/anyone bringing your child to services, medical doctors, referring providers, current therapist/doctors, etc.

I, _____ hereby give my informed consent to Chesapeake Speech Language Associates, LLC to:

- Disclose/exchange information/daily therapy progress to:

1. Name: _____

   Relationship to Child: _____

2. Name: _____

   Relationship to Child: _____

3. Name: _____

   Relationship to Child: _____

4. Name: _____

   Relationship to Child: _____

Purpose of disclosure is to discuss assessment, treatment, discharge planning.

Patient Name: _____ DOB: _____

Parent/Legal Guardian Signature: _____ Date: _____