Kathleen Rose-Le, M.S., CCC-SLP
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OFFICE USE ONLY	
ID	
DATE	
OTHER	

CONSENT FOR RELEASE OF INFORMATION

As the parent/guardian of ____, I hereby consent for the release of
FULL NAME OF CHILD

information _____ TO and/or _____ FROM the speech-language pathologists of **Communication & Learning Solutions Inc.** and its affiliates for the coordination of services for my child. Specifically, I consent for the following persons and/or entities to consult with **Communication & Learning Solutions Inc.**, via all means of communication, regarding my child's status in the areas of:

____ COMMUNICATION

____ BEHAVIOR

____ HEALTH/MEDICAL

____ ACADEMICS

NAME(S) OF PERSONS/ENTITIES:

____

____

____

____

By signing below, I understand that this consent will remain effective for one year from the date of signing and that I may withdraw this consent at any time.

____ ____________________
PARENT/GUARDIAN SIGNATURE DATE