OFFICE USE ONLY	
ID	
DATE	
OTHER	

speechperfect
SPEECH LANGUAGE SERVICES

CONSENT FOR RELEASE OF INFORMATION

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

information to Denise C. Elizondo and/or the speech-language pathologists of **Speech Perfect, LLC** and its affiliates for the coordination of services for my child. Specifically, I consent for the following persons and/or entities to consult with **Speech Perfect, LLC**, 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