Teach Beyond Speech, LLC.

(954) 532-8096

"Providing academically relevant speech and language therapy for children from preschool through adolescence."

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: ______________________________________ DOB:____________________

I, ____ (client or legal guardian), hereby authorize

Teach Beyond Speech to ☐SEND and/or ☐RECEIVE information ☐TO and/or ☐FROM:

Name of Person or Facility: _______________________________ Phone: ____________________

Address: ____

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☐ Academic Testing Results
☐ Behavior Programs
☐ Progress Reports
☐ Intelligence Testing Results
☐ School Records
☐ Personality Profiles
☐ Psychological Reports
☐ Psychological Testing Results
☐ Service Plans
☐ Summary Reports
☐ Medical Reports
☐ Entire Record
☐ Other (specify):

The above information will be used for the following purposes:

☐ Planning Appropriate Treatment of Program
☐ Continuing Appropriate Treatment or Program
☐ Determining Eligibility for Benefits or Program
☐ Case Review
☐ Updating Files
☐ Other (specify):

I understand that this authorization is voluntary and I may revoke consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purposes and who will receive the information. I understand that I have a right to receive a signed copy of this authorization. I understand that I have the right to refuse to sign this authorization.

Signed by: _________________________________ _________________________

Signature of Parent or Legal Guardian — Relationship to Patient

_________________________________ _________________________

Print Patient's Name — Date