AUTHORIZATION FOR RELEASE OF INFORMATION

Child's name:_____

I give permission for Children's Speech & Feeding Therapy, Inc. to exchange information regarding my child with the following individual(s):

_____	_____
Name of person/facility	**Name of person/facility**
_____	_____
Street address	**Street address**
_____	_____
City/Town, State, Zip code	**City/Town, State, Zip code**
_____	_____
Telephone number	**Telephone number**

_____

Parent signature **Date**

This release of information will be valid for a twelve month period from the date of signing.