phone: 586-307-4757
fax: 855-393-6740
email: office@nhspeech.com
web: www.nhspeech.com

AUTHORIZATION TO RELEASE INFORMATION

New Heights Speech and Language, PLLC will conduct a diagnostic evaluation and/or treatment on the child named below.

A copy of the evaluation report/interim report will be given to the responsible party after diagnosis/treatment. It should be known that it may be helpful to release this information to other care professionals in the future and/or that New Heights Speech and Language, PLLC may need to obtain information or records from other care professionals involved with your child.

By signing below, you acknowledge and authorize these practices.

Please list the authorized providers below, including address and phone number.

PROVIDER:

Address:

Phone:

Fax:

_____

Patient's Name D.O.B.

_____

Print Parent/Guardian Name Relationship to Patient

_____

Signature of Parent/Guardian Date