CONSENT TO RELEASE PROTECTED INFORMATION

I, _____, authorize the release of information

on behalf of _____ to enhance the

quality and coordinate services for my child.

_____
Name/Title/Facility/School District

_____
Address

_____
City State Zip

_____
Telephone Fax

Information to be released will include specific dates of Evaluations, Treatment Plans or Daily Notes:

_____

_____

_____

_____
Signature of Parent/Legal Guardian Date

Kidspeak, ltd.
specialized speech & language and occupational therapy services

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maple grove, mn 55311
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