



Clinical Release of Information

I, Mr./Mrs./Ms. _____, hereby give Chatterbox Pediatric Therapy Center permission to discuss my child's case with interdisciplinary professionals involved in his/her care, and to release any relevant clinical information to those professionals if requested. I also authorize Chatterbox Speech & Language Center to release and/or share any information requested by my insurance company.

(Client's Name)

Please list the professionals to which we may correspond:

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Signature of Patient/Caregiver: _____ Date: _____

**Document must be signed by parent or guardian if patient is under 18 years of age.

"Exceed client expectations...Coordinate individualized education plan goals and objectives with our comprehensive treatment plans"