Center for Communication and Learning LLC
Speech. Language. Social.

Release/Exchange of Information

Child's Name:_____

Parent's Name:_____

Address:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

I give permission for therapists/administrative staff at CCL to share information with any of the following people regarding the educational or medical treatment of my child. Please include schools, doctors, caregivers…

Name	Title	Telephone Number

I authorize representatives of CCL to leave messages via:

□ Email □ Text Message □ Home Phone □ Work Phone □ Mobile Phone

I authorize email communication to the following email accounts:

_____

□ Yes □ No I authorize release of information to my insurance company.

□ Yes □ No I authorize my child's physicians, educators and/or specialists to provide information to CCL in order to support the services being received at the center.

□ Yes □ No I hereby consent to emergency treatment for my child, if necessary. To the best of my knowledge there are no physical or other conditions that will interfere with his/her participation.

_____ _____

Parent/Guardian Signature Date