Lisa Langweil, M.S., CCC-SLP
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Authorization to Obtain/Release Information

Patient: _____
Date of Birth: _____

Information being Obtained/Released: (check all that apply)

_____ Phone contact (specify content) _____
_____ Speech-Language Evaluation/Progress Reports
_____ Clinical Assessment, Individualized Treatment Plan
_____ Email Containing Clinical Information

This authorization permits the sharing of the above-identified information between Lisa Langweil, M.S., CCC-SLP and:

Contact Person: _____
Phone: _____
Address: _____
_____
_____

Contact Person: _____
Phone: _____
Address: _____
_____
_____

I understand that the information being obtained/released is for the purpose of treatment planning. I understand that I may withdraw this consent at any time prior to the release of the above information and that withdrawal of this consent must be done in writing. I understand that refusal to grant consent will not impede my right to obtain present/future treatment so long as the disclosure is not deemed as necessary for providing appropriate clinical care. This consent will expire **one year** from the date of signature.

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____ Date _____
(Required for all patients 18 years and younger)