Grow & Tell, LLC

Speech-Language Pathology & Occupational Therapy Services
Phone: 717-512-2841
Email: jessicaover@growtellslp.com
www.growtellSLP.com

PERMISSION TO RECEIVE/RELEASE INFORMATION

CLIENT NAME: _____ DOB: _____

PARENT/GUARDIAN NAME (PRINTED): _____

PARENT/GUARDIAN PHONE NUMBER: _____

I hereby authorize the following to be released or received by Grow & Tell Speech-Language Pathology, LLC:

_____ Psychological Reports

_____Physician Reports/ Hospital or Clinic

_____Psychiatric Reports

_____ School Personnel Reports

_____ School Health Records

_____Other/ Specify:

The foregoing is to be released or received with the understanding that appropriate confidentially will be maintained according to HIPPA rules and regulations.

This release is in effect until further notification or until _____.

Identifying Name: _____

Address: _____

X _____ X _____

Signature Date

Parent/Guardian

Copies of this authorization shall be considered valid.