ACHIEVING BETTER COMMUNICATION
Speech & Language - Clear & Confident.

CONSENT FOR RELEASE OF INFORMATION

I, _____, authorize the release of information including therapy documentation, assessment, educational as well as verbal communication regarding my child:

Child's Name: _____Date of Birth:_____

From: Achieving Better Communication, LLC, 503 US Highway 70 E, Suite K, Garner, NC 27529; Office: 919-926-1466; Fax: 919-926-1377
To: Practice Name:

_____

Provider Name:

_____

Address:

_____

Phone/Fax:

_____

From: Practice Name:

_____

Provider Name:

_____

Address:

_____

Phone/Fax:

_____

To: Achieving Better Communication, LLC, 503 US Highway 70 E, Suite K, Garner, NC 27529; Office: 919-926-1466; Fax: 919-926-1377

*This information will be used for therapy (diagnostic and treatment) purposes only.

_____ _____

Parent Signature Witness

_____ _____

Date of Request Date of Signature

503 US HIGHWAY 70 E #K Garner, NC 27529
O. 919.926.1466 / F. 919.926.1377
info@abcspeechnc.com / www.abcspeechnc.com