Simplified Speech Solutions, LLC

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AAC • Consultation • Diagnostics • Therapy

Release of Information

I grant Simplified Speech Solutions, LLC permission to speak with or exchange information with the below listed individuals and/or organizations in order to share and/or obtain information regarding the clinical management of _____.
(Client's Name)

_____
Name Phone Number

_____
Name Phone Number

_____
Name Phone Number

_____
Name Phone Number

I understand that any information given to or released by Simplified Speech Solutions, LLC will be used to support the above client's clinical care and will be held confidential.

_____
Signature

_____
Relationship to client

_____
Date

Note: This form is considered valid for 1 year after the date signed.