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Speech-Language Development, SLP P.C.

Lyudmila Kimyagarova
Director

MACCC/TSHH P.R.O.M.P.T. trained-Level II
Speech-Language Pathologist
NYC License # 014994

AUTHORIZATION TO RELEASE /EXCHANGE OF INFORMATION

Patient name____

Date of Birth____

Parents' names____

Address____

City, State, Zip code____

Home phone____

I hereby authorize the release/exchange of medical records, school records, treatment notes, progress and evaluation reports, as well as, other pertinent information regarding treatment of this client between:

Speech-Language Development, SLP P.C.

And the following facilities, but not limited to: Primary Care Physician, Referring Physician, Schools, Insurance Company, Therapists and Hospitals:

Facility Name:____

Person/Professional:____

Address, City, State, Zip ____

Phone/Fax:______________________________/____________________________________

Signature: ___________________________ Date:____________________________