JO WORKINGER
Speech-Language Pathology, LLC

RELEASE OF INFORMATION

Child: _____ **DOB:** _____

I hereby authorize Jo Workinger, Speech-Language Pathology, LLC to consult with the following entities. Jo Workinger, SLP, LLC is permitted to request and/or share information deemed relevant for the coordination of services including test results, treatment plans, and clinical impressions.

Name: _____ Title: _____

Organization: _____

Phone: _____ Email: _____

Address: _____

Name: _____ Title: _____

Organization: _____

Phone: _____ Email: _____

Address: _____

Name: _____ Title: _____

Organization: _____

Phone: _____ Email: _____

Address: _____

I understand the records are protected under the federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time. I have read this consent and I understand it.

Legal Guardian Signature: _____ Date: _____

Legal Guardian Printed Name: _____

Relationship to Child: _____

2023-11