



Advantage Speech Therapy Services
e s t 2 0 0 4

CONSENT FORM

I agree to have my child, _____, receive a speech language therapy evaluation and/or treatment.

I would like my child to receive therapy at home / daycare (please circle).

CONFIDENTIAL RELEASE OF INFORMATION

I hereby authorize Advantage Speech Therapy Services, Inc. to obtain and/or release pertinent information concerning

_____ to *Robyn M. Drothler M.Ed. CCC-SLP.*

(child's name)

It is my understanding that this information will not be shared with any other entity without my prior knowledge. I further acknowledge that the use of this information is to ensure the best quality of care possible for my child.

Parent/Guardian

Date