CONSENT TO RELEASE INFORMATION

I authorize SLP Miami Therapy, Inc. to release necessary and pertinent medical information to physicians, case managers and insurance companies as needed for my child:_____

- Therapists
- Doctors
- Service Coordinators/Case managers
- Insurance Companies

Please list any other (s): _____

Approved information includes written documents and /or verbal discussion.

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date

CONSENTIMIENTO PARA LIBERAR INFORMACION

Yo autorizo a SLP Miami Therapy, Inc. a liberar información médica necesaria y pertinente a los médicos, encargados de caso, coordinadores de servicios y compañías de seguro cuando sea necesario para mi hijo: _____

- Terapeutas
- Medicos
- Coordiandores de Servicios/case managers
- Companias de Seguro

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date

SLP Miami Therapy, Inc.
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Slpmiamitherapy@gmail.com