CONSENT TO EVALUATE

I give Austin Area Speech and Language my permission to evaluate my child, _____. I understand that the results of the evaluation are confidential and will not be released to anyone without my written authorization.

_____ _____
Parent Signature Date

RELEASE OF INFORMATION

I authorize an exchange of information between Austin Area Speech and Language and the agencies and/or personnel listed below. I give my permission to relay information regarding my child's therapeutic records (evaluations, therapy notes, billing documents, etc.) via email with myself, my spouse and the following individuals:

_____

_____

_____

_____ _____
Parent Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign below to indicate you have received a copy of Austin Area Speech and Language Services' Notice of Privacy Practices on the date indicated. If you have any questions regarding our Notice of Privacy Practices, please contact Austin Area Speech and Language Services' Privacy Officer at 512-327-2083.

Patient Name: _____ Patient Date of Birth: _____
Patient Representative: _____ Relationship to Patient: _____
Signature: _____ Date: _____