CHAT
LIFE CHANGING
SPEECH THERAPY

310-D S. Main Street
Lombard, IL 60148

P 630.652.0200
F 630.652.0300

www.chatwithus.org

AUTHORIZATION FOR RELEASE/EXCHANGE OF CLIENT INFORMATION

This is to give permission to release and/or exchange confidential information by phone, fax, email or mail regarding:

_____
Client Name

This information includes any speech and language evaluation results, recommendations, and/or clinical information regarding this individual. This information is to be exchanged between the Center for Speech and Language Disorders dba CHAT and:

School/Office/Organization's Name: _____

Contact's Name:_____ Title/Role:_____

Address:_____

City:_____ State:_____ ZIP_____

Phone:_____ Fax: _____

Email:_____

Please check if the following applies:

☐ I authorize CHAT to obtain information regarding my child from the other named entity, but do not authorize CHAT to release information about my child at this time.

_____
Printed Name

_____ _____
Signature Date