Childhood Language Center, Inc.
Authorization for the Release of Information

Date_____

I, _____do hereby grant permission to the Childhood Language Center, Inc. to release information to assist in the evaluation, diagnosis, treatment, and/or education of _____ to the following doctors, schools, insurance companies, or persons.

Name	Address	Zip
Name	Address	Zip
Name	Address	Zip

Permission is granted to the Childhood Language Center, Inc.

( ) To release information to my child's doctor, insurance company or third-party payor (including physician if required by insurance company) for the purpose of processing my claim for benefits.

( ) To receive clinical information to assist in the evaluation, diagnosis, treatment, and/or education of _____from the provider(s) listed below.

Name	*Address*	*Zip*
Name	*Address*	*Zip*
Name	*Address*	*Zip*

Signature_____
Parent/Legal Guardian *Relationship*
Signature_____
Parent/Legal Guardian *Relationship*

Address_____

Phone _____