



CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Child's Name: _____ Birthdate: _____
Address: _____ City: _____ Zip: _____
Parent/Guardian: _____ Relationship to child: _____

By signing below, I grant my permission for the release and exchange of information pertaining to my child's medical, physical, educational and social/emotional condition and treatment between Sara S. Kemp and the following parties. I understand that I may revoke this consent at any time by giving notification in writing, except to the extent that action has been taken in reliance on it.

Information may be exchanged between
Sara S. Kemp SLP, INC.
Speech-Language Pathologist
2401 Bristol Court SW #D-103, Olympia, WA 98502
360-357-3339 Phone
360-528-3018 Fax
sara@pediatrictherapyolympia.com

~~and~~

	<i>Name</i>	<i>Address</i>	<i>Phone</i>
<i>Physician</i>	_____	_____	_____
<i>School District</i>	_____	_____	_____
<i>Other therapists</i>	_____	_____	_____
<i>Other specialists</i>	_____	_____	_____
<i>Other</i>	_____	_____	_____

Parent/Guardian Signature

Date

This form is the property of:
Sara S. Kemp SLP, INC.