



*Let's Talk Speech & Language Therapy Services, LLC*  
*Authorization to Release Information*

**AUTHORIZATION TO RELEASE INFORMATION**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission to Let's Talk Speech & Language Therapy Services, LLC to release verbal and/or written information to, and/or obtain information from the individuals/organizations listed below. I understand that I can withdraw or amend this authorization in writing at any time.

**Client or Parent/Legal Guardian Information if Client is under 18 years of age**

\_\_\_\_\_  
Name Relationship to client

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Email

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**Individuals/Organizations**

\_\_\_\_\_  
Name Relationship to client

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Email

\_\_\_\_\_  
Limitations of Disclosure (please exclude the above information)

\_\_\_\_\_  
Purpose of Disclosure

\_\_\_\_\_  
End Date (if no end date is specified, authorization will automatically end after a year)



*Let's Talk Speech & Language Therapy Services, LLC*  
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Name

Relationship to client

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Address

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Phone

Email

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Limitations of Disclosure (please exclude the above information)

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Purpose of Disclosure

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End Date (if no end date is specified, authorization will automatically end after a year)

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Name

Relationship to client

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Address

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Phone

Email

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Limitations of Disclosure (please exclude the above information)

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Purpose of Disclosure

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End Date (if no end date is specified, authorization will automatically end after a year)

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\_\_\_\_\_  
Print name (Client or Parent/guardian if client is under 18)

**X** \_\_\_\_\_  
Signature (Client or Parent/Guardian if client is under 18)