PRECISION THERAPY, LLC
Adult Consent Form
Phone: (315) 889-1690
Email: precisiontherapyllc@gmail.com

OFFICE USE ONLY	
ID	
DATE	
OTHER	

Patient Name:
Preferred Contact Number? Can message be left at this number? Yes No ____ Initial Here

CONSENT FOR RELEASE OF INFORMATION

I _____, hereby consent for the release of information from the
PATIENT/RESPONSIBLE PARTY
speech-language pathologists of **Precision Therapy, LCC** and its affiliates for the coordination of services. Specifically, I consent for the following persons and/or entities to consult with **Precision Therapy, LLC**, via all means of communication, regarding my status in the areas of:

Speech Therapy Evaluation, Speech Therapy Goals, Strategies, Progress, and Prognosis

Name	Relationship	Phone Number
1.		
2.		
3.		
4.		
5.		

I _____, **do / do not** authorize the release of information from the
PATIENT/RESPONSIBLE PARTY
speech-language pathologist of **Precision Therapy, LLC** and its affiliates to forward a copy of my speech and language evaluation to the primary care physician.

Primary Care Physician	Phone Number:

By signing below, I understand that this consent will be effective as of date signed below and that I may withdraw consent at any time.

_____ _____
PATIENT/RESPONSIBLE PARTY SIGNATURE DATE