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

OFFICE USE ONLY	
ID	
DATE	
OTHER	

Patient Name:
Parent/Caregiver Name(s):
Preferred Contact Number? Can message be left at this number? Yes No ____ Initial Here

CONSENT FOR RELEASE OF INFORMATION

As the parent/guardian of _____, I hereby consent for the release of
FULL NAME OF CHILD
information from the speech-language pathologists of **Precision Therapy, LCC** and its affiliates for the coordination of services for my child. Specifically, I consent for the following persons and/or entities to consult with **Precision Therapy, LLC**, via all means of communication, regarding my child's status in the areas of:

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

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

As the parent/guardian of _____, **do / do not** authorize the release
FULL NAME OF CHILD
of information from the speech-language pathologist of **Precision Therapy, LLC** and its affiliates to forward a copy of my child's evaluation to the treating pediatrician.

Pediatrician Name:	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.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE