Nancy L. Foreman & Associates L.L.C.

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CONSENT TO TREAT/RELEASE INFORMATION

Date: _____

I _____authorize Nancy L. Foreman
(Legal Guardian) Please Print

& Associates to Evaluate _____and/or provide Speech
(Patient Name) Please Print
and Language Therapy.

I, **(Please Print Name)** _____

authorize Nancy Foreman and Associates to release and obtain clinical information regarding:

_____

to and from the following persons or agencies.

_____

NAME **ADDRESS**

_____

NAME **ADDRESS**

_____

In consideration of treatment and educational purposes, I give consent that sound recordings, records, and/or photographs may be used as deemed helpful by the staff. I understand that the information may be discussed with other Speech Pathologist within the office and/or Patient Physician regarding evaluation and/or treatment goal strategies.

This form has been fully explained to me/us and I/we understand the contents.

_____

(Legal Guardian or Patient Signature) **Date**