



**RELEASE OF INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

I \_\_\_\_\_, give permission for Texas Speech Pathways to  
(name of parent/guarantor)  
contact the following physician/organization: \_\_\_\_\_ for  
past or current records needed for treatment.

Please check information to be released:

\_\_\_\_\_ Speech Evaluations

\_\_\_\_\_ Speech session notes

\_\_\_\_\_ Information concerning progress

\_\_\_\_\_ Information concerning patients behavior during sessions

\_\_\_\_\_  
(SIGNATURE OF PARENT/GUARANTOR)