small talk
PEDIATRIC SPEECH THERAPY LLC
LOOK WHOOO'S TALKING
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Wichita, KS 67208

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CONSENT FOR RELEASE OF INFORMATION

As the parent/guardian of _____, I hereby consent for the release of
FULL NAME OF CHILD

information _____ TO and/or _____ FROM the speech-language pathologists of **Pediatric Speech Therapy, LLC** and its affiliates for the coordination of services for my child. Specifically, I consent for the following persons and/or entities to consult with **Small Talk, Pediatric Speech Therapy**, via all means of communication, regarding my child's status in the areas of:

____ COMMUNICATION

____ BEHAVIOR

____ HEALTH/MEDICAL

____ ACADEMICS

NAME(S) OF PERSONS/ENTITIES:

_____

_____

_____

_____

By signing below, I understand that this consent will remain effective for one year from the date of signing and that I may withdraw this consent at any time.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE