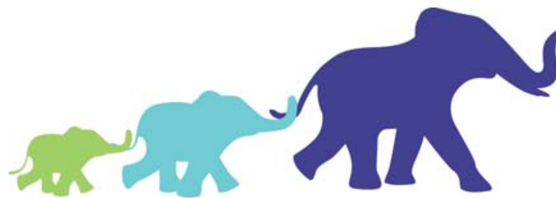

Consent to release information

I, ____ am giving Pediatric Feeding & Speech Solutions, PLLC
(Printed name of parent or guardian)

consent to discuss and share medical information about ____
(Printed name of child)

with the following professionals and/or agencies:

Name of professional or agency	Address/ Phone/ Fax
____	_________________________________
	_________________________________
____	_________________________________
	_________________________________
____	_________________________________
	_________________________________

____ ________________________________
Parent/Caregiver Date

____ ________________________________
Therapist Date

704 South King Street, Suite #1, Leesburg, VA 20175 Phone: 703-771-2200 Fax: 703-771-7080
pediatricfeedingandspeech.com