Center for Speech, Language, and Learning Inc.

6230 Tenth St., Suite 220
Oakdale, MN 55128
651-739-2300
651-739-2302 fax

Consent for Release of Information

Patient Name:	Date of Birth:
Parent(s):	
Address:	
City, State, Zip	
Social Security Number:	Phone:

I authorize Center for Speech, Language and Learning, Inc to:

- ☐ **Communicate verbally**
- ☐ **Communicate in Writing**
- ☐ **Request records and information**

With the following individuals and/or organizations:

Name: **Address:** **Phone:**	**Name:** **Address:** **Phone:**
Name: **Address:** **Phone:**	**Name:** **Address:** **Phone:**

- I understand that my consent to release records is completely voluntary and may be revoked at any time by providing that directive in writing to this organization.
- In consenting, I understand information obtained is confidential and may be used only for the purposes discussed and may not be released to other requestors without my consent.
- I understand this consent is not required for consideration for services and my health care will not be affected if I do not sign this form.
- I understand I may see and request a copy of information received and that this organization reserves the right to charge me for said copies.
- I have been informed that Center for Speech, Language and Learning, Inc. will not receive financial or other compensation for disclosing the health information described above.
- I authorize CSLL Inc. staff to contact me regarding my child via email using the email address that I have provided to them.
- I authorize CSLL Inc. to leave messages on my voicemail.

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Parent/Legal Guardian/Patient   Date