Northrup & Associates

Speech Pathology
Oral Myology

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I give my approval for _____
(Name of Doctor or Therapist)

to share any information regarding _____
(Name of Client)

with Northrup & Associates, Speech/Language Pathologists.

_____ _____ _____
(Date) (Signature) (Relationship)

Permission is granted to Northrup and Associates, Speech Pathology group, to share information

regarding _____ with:
(Clients name)

_____
Name SCHOOL Address

_____
Name PHYSICIAN Address

_____
Name OTHER PROFESSIONAL Address

_____ _____ _____
Date Signature Relationship