



## Permission for Release of Information

### Client Information

<b>Last Name:</b>	<b>First Name:</b>	
<b>Address:</b>		
<b>Date of Birth:</b>	<b>Age:</b>	<b>Grade:</b>

I hereby authorize the following school(s), person(s), agency(ies), doctor(s), hospital(s), and/or others named below to exchange pertinent information to aid in the planning of the education, therapy or treatment program for \_\_\_\_\_

<b>Name of Agency:</b> Communi-Capable	<b>Name of Agency:</b>
<b>Address:</b> Bellingham, WA	<b>Address:</b>
<b>Phone:</b>	<b>Phone:</b>
<b>Fax:</b>	<b>Fax:</b>
<b>Email:</b> <a href="mailto:dyanncw@communicapable.com">dyanncw@communicapable.com</a>	<b>Email:</b>
<b>Contact Person/Title:</b> Dyann Castro-Wehr, SLP	<b>Contact Person/Title:</b>
<b>Name of Agency:</b>	<b>Name of Agency:</b>
<b>Address:</b>	<b>Address:</b>
<b>Phone:</b>	<b>Phone:</b>
<b>Fax:</b>	<b>Fax:</b>
<b>Email:</b>	<b>Email:</b>
<b>Contact Person/Title:</b>	<b>Contact Person/Title:</b>

This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ or one year from the date of the signature and allows the exchange of information to go to, from, and between the persons and agencies listed above. Authorization is subject to written revocation by the undersigned at any time and will be in effect upon receipt of such notice.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Relationship:** Client/Parent/Guardian/Conservator (please circle)