
## *CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION*

Child's Name:_____ Birthdate:_____

Address:_____City:_____Zip:_____

Parent/Guardian:_____Relationship to child:_____

By signing below, I grant my permission for the release and exchange of information pertaining to my child's medical, physical, educational and social/emotional condition and treatment between Sara S. Kemp and the following parties. I understand that I may revoke this consent at any time by giving notification in writing, except to the extent that action has been taken in reliance on it.

Information may be exchanged between
**Sara S. Kemp SLP, INC.**
**Speech-Language Pathologist**
**2401 Bristol Court SW #D-103, Olympia, WA 98502**
**360-357-3339 Phone**
**360-528-3018 Fax**
**sara@pediatrictherapyolympia.com**

**~~and~~**

| | ***Name*** | ***Address*** | ***Phone*** |
|---|---|---|---|
| ***Physician*** | | | |
| ***School District*** | | | |
| ***Other therapists*** | | | |
| ***Other specialists*** | | | |
| ***Other*** | | | |

_____ _____
Parent/Guardian Signature Date

This form is the property of:
Sara S. Kemp SLP, INC.