



Wake Pediatric Speech Therapy

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CONSENT FOR SERVICES AND EXCHANGE OF INFORMATION

I hereby grant Wake Pediatric Speech Therapy, PLLC permission to provide services to my child, which may include a speech and language screening, evaluation, and/or therapy.

I also authorize Wake Pediatric Speech Therapy, PLLC to release information in my child's record, including evaluation results, goals, therapy notes, or progress notes to:

- My child's pediatrician:
- _____
- The CDSA
- Other: _____

The purpose of any exchange will be to coordinate patient care.

I understand that this consent is voluntary and that I may revoke this consent in writing at any time.

Patient Name

Date of Birth

Parent / Guardian Name

Date