

speech. language. connection.

30 Old Kings Highway, 2nd Floor
Darien, CT 06820

Shelly Ransom, M.S., CCC-SLP
Speech Language Pathologist
shellyransomslp@gmail.com

PERMISSION TO OBTAIN OR RELEASE INFORMATION

Name of Child or Client	Date of Birth
<input type="text"/>	<input type="text"/>

I hereby give consent to Shelly Ransom, MS, CCC-SLP to obtain/release all pertinent information concerning (please check one):

My Child Myself

Name:	<input type="text"/>
Agency:	<input type="text"/>
Street:	<input type="text"/>
City, State, Zip	<input type="text"/>
Phone Number	<input type="text"/>
Fax Number	<input type="text"/>

Information that may be obtained can include (check all that apply):

<input type="checkbox"/>	Clinical Impressions and Records	<input type="checkbox"/>	Psychological Evaluations
<input type="checkbox"/>	Academic Records (cumulative records, report cards, standardized test scores, etc.)	<input type="checkbox"/>	Special Education Records/504 Plan Records (IEP, 504 Plans, PPT/Student Study Team minutes, evaluations)
<input type="checkbox"/>	Health Records	<input type="checkbox"/>	Educational Evaluations
<input type="checkbox"/>	Social Work Evaluations	<input type="checkbox"/>	Speech and Language Evaluations
<input type="checkbox"/>	Psychiatric Evaluation	<input type="checkbox"/>	Other Evaluations (vocation, occupational, etc.)
<input type="checkbox"/>		<input type="checkbox"/>	Other

ACTUAL SIGNATURE:

Name (Print Name)	Relationship	Signature	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

OR

ELECTRONIC SIGNATURE:

BY CHECKING THE ELECTRONIC SIGNATURE BOX YOU ACKNOWLEDGE THAT YOU HAVE READ THE DOCUMENT AND AGREE TO THE TERMS AND CONDITIONS.