CENTRAL TEXAS
SPEECH PATHOLOGY SERVICES, INC.

RELEASE OF INFORMATION

I, _____, do hereby give my consent for _____ to release information to:

Central Texas Speech Pathology Services, Inc.
2525 Wallingwood Drive, Bldg. 2
Austin, Texas 78746

Service dates *from* _____ *to* _____.

List information requested:

_____

_____

_____

_____

_____

_____

_____

_____

Patient: _____ _____

Signature

DOB: _____ _____

Relationship to Patient

_____

Date

Lisa Famiglietti, M.S., CCC-SLP/A, Director
2525 Wallingwood, Bldg. 2 Austin, Texas 78746 512/327-6179