

Olmos Speech, Language and Learning Clinic

5800 Broadway, Suite 106 / San Antonio, Texas 78209/ 828-5583 - Fax (210) 828-4129

CONSENT FOR RELEASE OF INFORMATION

I, _____, on this day, _____
(Patient/Guardian) (Date)

authorize Olmos Speech, Language, and Learning Clinic to release and obtain clinical

Information for _____ as it relates to treatment, authorization
(Patient)

for treatment and for purposes of insurance reimbursement. I understand that this

may be shared with insurance companies, physician's offices, and/or other required

medical/educational offices as it relates to the treatment of the above patient.

CONSENT FOR TREATMENT

I, _____, on this day, _____
(Patient/Guardian) (Date)

authorize Olmos Speech, Language, and Learning Clinic to evaluate and/or provide speech

therapy treatment and services for _____.
(Patient)

Signature of Parent/Guardian: _____

Date: _____