



Verbal Expressions, Inc

## Release of Confidential Information

TO: (Person/Agency Releasing Records) Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You are requested and authorized to release confidential medical (i.e. prescriptions for services, plan of care, insurance payments, Explanation of Benefits, etc.) social, psychological, psychiatric, or educational information/records to Verbal Expressions, Inc. that you have or may receive pertaining to my child:

**Child's Full Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

Verbal Expressions, Inc. may also release confidential speech-language records to the above named individual (i.e. physician), or company on my child.

\_\_\_\_\_  
Parent/Guardian Signature Date