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## AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Alissa Suski, M.A., CCC-SLP by other individuals or agencies. Such requests should be referred to the original individual or agency.

I \_\_\_\_\_ authorize Alissa Suski, M.A., CCC-SLP to:  
Parent/Guardian Name (Please Print)

- release to:
- obtain from:
- exchange with:

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the following information pertaining to my child \_\_\_\_\_:

- speech/language evaluation
- diagnosis
- treatment summary
- dates of treatment attendance
- other (specify) \_\_\_\_\_

for the purpose of:

- evaluation/assessment and/or coordinating treatment efforts
- other (specify) \_\_\_\_\_

This consent is active while this student is enrolled at St. Junipero Serra Catholic School.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

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Parent/Guardian Name (Please Print) Relationship to Student

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Signature Date

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Parent/Guardian Name (Please Print) Relationship to Student

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Signature Date

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Signature of Witness Date

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