

SPEECH THERAPY ASSOCIATES

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Release for Audio/video recordings (*please check*):

- Evaluation purposes and for creating effective treatment plans.
- Materials to educate other medical professionals.
- Display or promotional materials. No names will be used.

Release of Information:

Re: _____ Date of Birth: _____
(client's name)

I, _____, authorize the mutual exchange of information related to matters of therapeutic, educational and medical management by telephone, direct contact, written or e-mail format between the following persons and/or agency representative:

Agency/Individual: Address:
Agency/Individual: Address:
Agency/Individual: Address:

Signature (Parent/Guardian/Self) Date: _____

Please send records to: Speech Therapy Associates, 12555 SW 3rd Street, Beaverton, OR 97005