

CONSENT TO EVALUATE

I give Austin Area Speech and Language my permission to evaluate my child,
_____. I understand that the results of the evaluation are
confidential and will not be released to anyone without my written authorization.

Parent Signature

Date

RELEASE OF INFORMATION

I authorize an exchange of information between Austin Area Speech and Language and the
agencies and/or personnel listed below:

Parent Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign below to indicate you have received a copy of Austin Area Speech and Language
Services' Notice of Privacy Practices on the date indicated. If you have any questions regarding
our Notice of Privacy Practices, please contact Austin Area Speech and Language Services'
Privacy Officer at 512-327-2083.

Patient Name: _____ Patient Date of Birth: _____

Patient Representative: _____ Relationship to Patient: _____

Signature: _____ Date: _____