



OFFICE USE ONLY	
ID	
DATE	
OTHER	

Rosalie Fowler, M.S., CCC-SLP
Moxie Speech Services
Phone: 770-975-2870
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CONSENT FOR RELEASE OF INFORMATION

As the parent/guardian of _____, I hereby consent for the release of
FULL NAME OF CHILD

information ____ TO and/or ____ FROM the speech-language pathologists of Moxie Speech Services, LLC and its affiliates for the coordination of services for my child. Specifically, I consent for the following persons and/or entities to consult with Rosalie Fowler via all means of communication, regarding my child's status in the areas of:

- ____ COMMUNICATION
- ____ BEHAVIOR
- ____ HEALTH/MEDICAL
- ____ ACADEMICS

NAME(S) OF PERSONS/ENTITIES:

By signing below, I understand that this consent will remain effective for one year from the date of signing and that I may withdraw this consent at any time.

PARENT/GUARDIAN SIGNATURE

DATE