

Information Release Form

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I authorize Jill G. Russell to consult, exchange diagnostic and therapy information with the following professionals regarding:

Client's Name: _____ DOB: _____

	Name	Date
Orthodontist	_____	_____
Dentist	_____	_____
Physician	_____	_____
Allergist	_____	_____
ENT	_____	_____
School SLP	_____	_____
Insurance(s)	_____	_____
OTHER:	_____	_____
OTHER:	_____	_____

Signature: _____ Date: _____

Relationship: _____