AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
MUTUAL EXCHANGE OF INFORMATION

Today's Date: ________________

Patient Name: ____ **Birthdate:** ___________________
Parent(s) Name: ____
Address:____
City/State/Zip:____

I hereby authorize the release of the following records and/or a mutual exchange of privileged information

Health / Medical Records   School Records   Other ________________________________
____

FROM	Person / Agency: Street Address: City/Sate/Zip:

TO		
	Person / Agency:	**CAROL LORIOUX LOUP, M.A., CCC-SLP / Clear Speech Inc**
	Street Address:	**3602 EVERETT AVE.**
	City/Sate/Zip:	**EVERETT, WA 98201** 425/259-7285 Phone 425/259-6317 Fax

EXPLANATION FOR RELEASE OF RECORDS (IF APPROPRIATE):

I understand that this information will be treated confidentially and will not be transmitted to a third party without my express permission.

Signed: ____________________________________ Relationship to patient: ___________________________

Printed Name: ______________________________ Date: ____

CAROL LORIOUX LOUP, M.A., CCC-SLP 3602
EVERETT AVE. EVERETT, WA 98021
PHONE 425/259-7285