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Release of Information

I grant Simplified Speech Solutions, LLC permission to speak with or exchange information with the below listed individuals and/or organizations in order to share and/or obtain information regarding the clinical management of _____.

(Client's Name)

Name

Phone Number

Name

Phone Number

Name

Phone Number

Name

Phone Number

I understand that any information given to or released by Simplified Speech Solutions, LLC will be used to support the above client's clinical care and will be held confidential.

Signature

Relationship to client

Date

*This is valid for one year from the date of signing

