815 Blooming Grove Turnpike,
Suite 601
New Windsor, NY 12553
(845) 527-2089

I, ______________________________, authorize Hudson Valley Speech and Swallowing Therapy PLLC to release medical information to the following individuals and/or organizations:

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Please indicate information to be shared

- ☐ Discussion of medical history
- ☐ Discussion of progress
- ☐ Discussion of future goals
- ☐ Discussion of therapy techniques
- ☐ Release of Evaluation and updated progress reports

I do not want the following information discussed: ____________________

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Patient/Guardian Signature: ______________________________

Printed name:

Date: ________________

Witnessed by: ____