Suzy DiIorio
M.S., CCC-SLP
PEDIATRIC SPEECH-LANGUAGE PATHOLOGIST
Empowering children to reach their highest potential

Authorization to Release Information

Child's Name: _____

I understand this release is voluntary and applies to all services under Suzy DiIorio, LLC. I give Suzy DiIorio permission to discuss my child's case with in the interdisciplinary professionals in order to coordinate services. This would include treatment plans, progress notes and general discussion of the child. Individuals would include child's pediatrician, other physicians, school teacher, school SLP, case manager, occupational therapist and other specialists (e.g. psychologist). If there are any individuals and/or facilities to whom you do not wish to information to be released, please list them below:

_____

_____

_____

Signature of Parent or Legal Guardian: _____

Print Name of Person signing form: _____