

1st Choice Therapy, LLC
Certified Speech Language Pathologist
www.simplyspeakingsspeech.com

CONSENT TO TREAT

Date: _____

I, _____ authorize 1st Choice Therapy, LLC
(Legal Guardian Print Name)

to evaluate _____ and/or provide Speech and Language Therapy.
(Patient Name Please Print)

RELEASE OF INFORMATION

I, _____ authorize 1st Choice Therapy, LLC to release
(Legal Guardian Print Name)

and obtain clinical information regarding: _____
(Patient Name Please Print)

to and from the following persons or agencies:

Name Address

Name Address

This form has been fully explained to me/us and I/we understand the contents.

(Legal Guardian or Patient Signature) Date