Jodie K. Schuller & Associates
Therapies For Success

CONSENT FOR RELEASE OF INFORMATION

By giving us written permission to share information with every related professional along with their addresses and phone numbers, you will expedite your results.

This authorizes Jodie K. Schuller & Associates to consult, exchange diagnostic and therapy Information with the following professionals regarding:

Client's Name: _____ **DOB:** _____

Practitioner Specialty	Practitioner Name	Practitioner Address	Phone #	Initials & Date
Pediatrician/ Physician		**E-mail:**		
Orthodontist		**E-mail:**		
Dentist		**E-mail:**		
Home Room Teacher		**E-mail:**		
Speech & Language Specialist		**E-mail:**		
Optometrist /Ophthalmologist		**E-mail:**		
Resource Specialist		**E-mail:**		
Psychologist/Psychiatrist		**E-mail:**		
Allergist		**E-mail:**		
ENT		**E-mail:**		
Advocate		**E-mail:**		

To expedite treatment, we will share reports with the appropriate professionals.

Signature: _____ Date: _____

Relationship: _____