



ASSOCIATED
SPEECH &
LANGUAGE
SPECIALISTS LLC

Patient/Parent Permission to Obtain/Release Information

Patient Name: _____ DOB: _____

Parent Name: _____

Address: _____

Phone Number: _____

I, the undersigned, hereby request and authorize:

Associated Speech & Language Specialists, LLC

Attn: _____

(circle location)

SAINT PAUL

561 West 7th St
Saint Paul, MN 55102
651/225-4558
(fax) 651/225-9474

561 West 7th St
St Paul, MN
55102
(651) 225-4558
f:(651) 225-9474

1260 W County Rd E
Arden Hills, MN
55112
(651) 639-0942
f:(651) 639-1718

3001 Harbor Lane N
Suite 120
Plymouth, MN
55447
(763) 551-3652
f: (763) 551-1334

1705 Cope Ave E
Suite G
Maplewood, MN
55109
(651) 773-3208
f: (651) 773-0371

ARDEN HILLS

1260 W County Rd E
Arden Hills, MN 55112
651/639-0942
(fax) 651/639-1718

to *release to:*

Name: _____

exchange with:

Address: _____

obtain from:

Fax #: _____

Phone #: _____

PLYMOUTH

3001 Harbor Lane N
Suite 120
Plymouth, MN 55447
763/551-3652
(fax) 763/551-1334

the information which I have indicated below:

MAPLEWOOD

1705 Cope Ave E
Suite G
Maplewood, MN 55109
651/773-3208
(fax) 651/773-0371

The purpose of this release of information is to coordinate care and services provided with ASLS. This permission is valid for one year from the date signed. A copy of this form is as effective as the original.

Signature of patient, parent, or legal guardian

Date