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Communication Authorization

Client Name: _____

Date of Birth: _____

Notice to Patient/Guardian:

Please indicate below the names and contact information for whom I may contact re; you or your child's care. Examples of contact may be to leave phone messages, which may or may not include detailed information re: treatment or evaluation, or to communicate with physicians, school personnel, other health specialists, or other family members or nannies who may be bringing your child to appointments.

Kidzspeech, LLC has my permission to release information about the above-named patient and/or make contact with the following sources by whatever means necessary. (Source examples: yourself, your family, personal physician, health specialist, hospital, school, therapists, or organization.)

Form with four rows for contact information, each row containing fields for Name, Address, and Phone.

May we contact you via email re: treatment, scheduling, or invoices/payment) (please circle): Yes No

If Yes, what is your preferred email address: _____

May we contact you via phone and leave messages on voicemail or with whomever answers the phone? (please circle): Yes No

If yes, please list below the phone numbers that may be used to contact you:

Home: _____ Cell: _____

Other: _____ Other Cell: _____

Work: _____

By signing below, I agree to have Kidzspeech, LLC contact and/or communicate with the above-named persons/organizations. I understand that I may revoke this treatment consent or release at any time by written request to the extent that action has not already been taken.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____