



# Southern Connecticut State University

501 Crescent Street  
New Haven, CT 06515 -1355



Department of Communication Disorders  
Clinical Services  
Davis Hall Room 012  
203.392.5955

NAME:

DATE:

DATE OF BIRTH:

ADDRESS:

PARENT /GUARDIAN:

I give permission for the exchange of information as indicated below with the following persons/agencies:

1)  receive     send

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(circle all that apply): verbal consultation, written reports: audiology, speech & language, other \_\_\_\_\_

2)  receive     send

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(circle all that apply): verbal consultation, written reports, audiology, speech & language, other \_\_\_\_\_

3)  receive     send

\_\_\_\_\_

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\_\_\_\_\_

(circle all that apply): verbal consultation, written reports, audiology, speech & language, other \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

PLEASE MAIL TO:    Clinical Director,  
Department of Communication Disorders  
SCSU, Davis Hall, Room 012  
501 Crescent Street  
New Haven, CT 06515

