Dr. Alvin Frostad
Dr. Lennis Boyer
Dr. Malini Ariyawansa
Dr. Michael Frostad
Dr. Amy Kinkel
Dr. Methuel Gordon

1205 SE Professional Mall Blvd., Pullman, WA 99163
Phone (509) 332-2605 • Fax (509) 334-5754

In order to provide complete services for your child, ___________________________,
We may need pertinent information from other individuals or agencies working with your family. We may also need to share information with others so that they can provide better services. Please check the agencies or persons listed below from whom we may receive and to who we may give information if it is necessary. Please include names of doctors when appropriate. We will need your signature for both sections.

Family Doctor Name ____________________ Mental Health Clinic _______________

Specialist's Name _______________________ Dept. of Public Assistance __________

Communication Disorders Clinic ____________ Crippled Children's Services ________

Human Relations Center __________________ __________________School District

Other ________________________________ Other ___________________________

Parent Signature _________________________________ **Date** _______________

Family Doctor Name ____________________ Mental Health Clinic _______________

Specialist's Name _______________________ Dept. of Public Assistance __________

Communication Disorders Clinic ____________ Crippled Children's Services ________

Human Relations Center __________________ __________________School District

Other ________________________________ Other ___________________________

Parent Signature _________________________________ **Date** _______________