AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Speech Path & Pastures, LLC
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Speech Path and Pastures, LLC
Making Communication Natural

PATIENT INFORMATION

Full Name: _____

Date of Birth: _____

Parent/Guardian Name (if applicable):_____

Phone Number: _____

Email Address: _____

RELEASE INFORMATION

I authorize the release of my/my child's records:

☐ From ☐ To

Name/Facility: _____

Phone: _____ Email: _____ Fax: _____

Address: _____

☐ From ☐ To

Name/Facility: _____

Phone: _____ Email: _____ Fax: _____

Address: _____

INFORMATION TO BE RELEASED

☐ Evaluations
☐ Progress notes
☐ Plan of care
☐ Attendance records
☐ Audiology reports
☐ Educational/psychological assessments
☐ Other: _____
Service Dates: From _____ To _____

PURPOSE OF RELEASE

☐ Coordination of care
☐ School planning
☐ Insurance
☐ Legal
☐ Personal use
☐ Other: _____

SENSITIVE INFORMATION (IF APPLICABLE)

This may include developmental, mental health, or other sensitive data.
☐ I authorize inclusion of this information
☐ I do NOT authorize inclusion of this information

EXPIRATION

This authorization expires:
☐ One year from today
☐ On: _____
☐ Once request is fulfilled

PATIENT RIGHTS

I may revoke this at any time in writing, except where disclosure has already occurred.
Information released may no longer be protected by HIPAA.
Signing is voluntary and care will not be affected by refusal.
I may request a copy of this authorization.

SIGNATURE

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____ (if applicable)