SeaGlass speech therapy

## Authorization for Disclosure of Patient Information

Client Name: _____ Date of Birth: _____

I, _____ (print name), certify that I am the parent/legal guardian of the child named above and hereby authorize the release/exhange of information between SeaGlass Speech Therapy, PLLC and the following persons and/or agencies for the purposes of assesment, treatment planning, and/or coordination of services:

Physician Name: _____

Address: _____

Phone: _____ Fax: _____

Please select which documentation may be released/exchanged. More than one may be selected. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

☐ Evaluation Report ☐ Treatment Notes ☐ Discharge Summary ☐ Evaluation Report

☐ Periodic exchange of clinical information

☐ Other (specify) _____

**Release Authorization**

I understand that the federal privacy law protecting health information may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. I understand what information will be released, the purpose for the release of the information, and that there are statutes and regulations protecting the confidentiality of the information. SeaGlass Speech Therapy, PLLC's 'Notice of Privacy Practices' describes the circumstances where disclosure is permitted or required by state or federal laws.

I understand the terms of the Authorization for Disclosure and voluntarily give my authorization. I understand that I may refuse to sign this authorization form. SeaGlass Speech Therapy, PLLC will not condition my evaluation or treatment on receiving my signature on this authorization. I further understand that I may revoke this authorization by written request at any time. Such revocation does not affect the validity of my authorization for information disclosed/released prior to revocation. If not revoked earlier, this authorization expires one year from the date it is signed.

Signed: _____ Date: _____

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