MEDICAL RECORDS RELEASE FORM

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I, _____, of _____, date of birth: _____ hereby authorize **Speech Matters, LLC** to use, disclose and/or discuss the following protected health information listed below from my medical records. I understand the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting confidentiality.

2. Persons or entities with whom Speech Maters, LLC may disclose/discuss your Protected Health Information (Releasees- i.e. Doctors, Dentists, Therapists, Schools/Teachers, etc.)

_____
Name City/State

_____
Name City/State

_____
Name City/State

_____
Name City/State

3. Speech Matters, LLC is authorized to disclose/discuss the following information for treatment dates

_____ to date and continuing:

_____ My medical records
_____ My treatment records (progress notes, daily records)
_____ My speech, language, and/or swallowing test results
_____ Evaluations/therapy progress
_____ Other: _____

4. This information is being used or shared for:

____ Medical _____ Insurance _____ Legal _____ Education

5. I understand that I may revoke this authorization at any time by requesting such of Speech Matters, LLC in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

6. This authorization expires upon discharge from therapy.

_____ _____
Printed Name of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Relationship to Patient