MEDICAL RECORDS RELEASE FORM
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I, ______________________________, of ______________________________, parent/guardian of
(Parent/Guardian) (City, State)

___________________________date of birth: _________ hereby authorize Speech Matters, LLC to use, disclose
(Client Name)

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 / Title	Address	Contact information (phone and/or email)

3. Speech Matters, LLC is authorized to disclose/discuss the following information, including but not limited to: medical records; treatment records (progress notes, daily session notes); speech, language, academic, and/or swallowing test results; and evaluations/therapy progress as it relates to therapy/treatment and evaluations at Speech Matters, LLC.

4. This information is being used or shared for medical, insurance, legal, and/or educational purposes.

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.

______________________________ ______________________________
Parent/Guarantor Signature Date

______________________________ ______________________________
Parent/Guarantor Name (Printed) Client Name (Printed)