Speech and Language Therapy Express
(813) 438-6948
kelly@sltherapyexpress.com
www.sltherapyexpress.com

HIPAA Acknowledgement & Authorization Form

Patient Name (printed/typed): _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge by signing below that I have received and read, or had explained to me, the "Notice of Privacy Practices" for Speech and Language Therapy Express, LLC.

Guardian Name (printed/typed): _____

Guardian Signature: _____Guardian Initials: _____

****CONSENT FOR RELEASE OF INFORMATION**: I consent to the release of my child's protected health information for professional use to the following entities who are also involved in my child's care, even though I understand that Speech and Language Therapy Express, LLC is legally permitted to use or share my child's protected health information, as needed, without my permission for certain reasons as explained in the "Notice of Privacy Practices."

Please mark all that apply.

- ☐ Doctor, Pediatrician
- ☐ Medical Specialist(s)
- ☐ Services Coordinator
- ☐ Early Interventionist
- ☐ ABA Therapists & Related Personnel
- ☐ Speech-Language Pathologist(s)
- ☐ Physical Therapist(s)
- ☐ Occupational Therapist(s)
- ☐ Local School District & Teachers
- ☐ Other: _____

Guardian Initials: _____

HIPAA AUTHORIZATION: I hereby authorize the use/disclosure of my child's protected health information as described below:

1. Confidential information is stored in a secure location away from public access. All business computers containing confidential information are only accessed by password and are secured by computer and internet protection software (antivirus, antispyware, etc.)
2. Speech and Language Therapy Express, LLC is authorized to disclose pertinent protected health information to insurance companies or referring physicians for the purposes of requesting doctor's orders, authorization for service and/or to obtain reimbursement for services. Information may be sent via mail, fax, electronic or e-fax, e-mail or phone with procedures in place to limit the likelihood of unauthorized access. The date sent will be documented by the responsible office personnel.
3. Speech and Language Therapy Express, LLC and its employees are authorized to use or disclose pertinent protected health information that is required for speech-language service purposes.

4. Speech and Language Therapy Express, LLC may disclose protected health information considered pertinent to speech-language services to specified professionals (e.g., early interventionists, service/care coordinators, teachers, psychologists, physicians, social workers, therapists, etc.) without a signed release form.
5. I, the parent/guardian, understand that all employees of Speech and Language Therapy Express, LLC are given a copy of the "Notice of Privacy Practices", sign a confidentiality agreement and will only have access to information required to complete their job responsibilities.
6. I, the parent/guardian, may revoke this authorization by notifying Speech and Language Therapy Express, LLC in writing of my desire to revoke it. However, I understand that any action already completed prior to the request to revoke this authorization cannot be reversed, and my revocation will not affect those actions.
7. This authorization expires when the client is discharged from therapy, although Speech and Language Therapy Express, LLC will always use professional discretion when sharing any protected health information.

Guardian Initials: _____