Speech Inspiration, PLLC

AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION

PATIENT'S NAME_____DATE OF BIRTH:_____

Address:_____

I authorize (name) _____

(Address)_____

(Email Address)_____(FAX)_____

to allow or disclose information and/or records (as identified below) regarding my/my child's academic achievement, treatment, medical and/or behavioral health condition to Speech Inspiration, PLLC, 7122 Midnight Pass, Missouri City, TX 77459; PHONE: 281-674-4205, FAX 480-287-8474. Information to be released or exchanged includes (check all that applies):

_____ Most recent medical exam (specify)_____

_____ Hospital Discharge Summary (specify date of discharge)_____

_____ Most recent audiogram or hearing test

_____ Medication Records

_____ Speech Pathology records (most recent evaluation, most recent progress notes, plan of care)

_____ Occupational Therapy records (most recent evaluation, most recent progress notes, plan of care)

_____ Physical Therapy records (most recent evaluation, most recent progress notes, plan of care)

_____ School records (most current full and individual evaluation, current annual goals, most recent progress report)

_____ Classroom Academic Observation by: Jeanene Johnson, M.A. CCC-SLP, Speech Inspiration, PLLC

_____ Other (specify):_____

Speech Inspiration, PLLC

The authorized purposes for this release are:

_____ Diagnosis and treatment

_____ Coordination of Care

_____ Insurance payment

_____ Other (specify):_____

I understand that my/my child's health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization at any time. This authorization is valid until I revoke it or 60 days after I or my child has completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me as I signed it of my own free will on:

The _____day of _____, 20_____.

_____ _____

Signature of Patient, Guardian, or Authorized Representative

Signature of Witness

_____ _____

Print Name: Patient, Guardian, or Authorized Representative

Print Name: Witness