Speech Inspiration, PLLC

Authorization for Release of Information

I authorize Speech Inspiration, PLLC to disclose

_____(Name) speech and language records to:

_____(print name) at

_____(street,city,state, zip)

and,

_____(print name) at

_____(street,city,state, zip)

and,

_____(print name) at

_____(street,city,state, zip)

and,

_____(print name) at

_____(street,city,state, zip)

I understand that I have a right to revoke the authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to speech inspiration, PLLC at:

Speech Inspiration, PLLC

7122 Midnight Pass

Missouri City, TX 77459

Speech Inspiration, PLLC

Authorization for Release of Information continued

I understand that revocation will not apply to information that has already been disclosed in reliance on the authorization.

This authorization is effective from_____ (date) and continues until I cancel it as noted above or the expiration of two years from the date of my signature. The authorization covers any speech and language records that are created after this authorization is signed.

I further understand that the information disclosed may be re-disclosed by the recipient if the recipient is not a covered entity(health care provider or facility) or business associates of the covered entity and may no longer be protected by the federal and state privacy regulations.

I understand that I may refuse to sign this authorization and that any treatment, payment or my enrollment in a health plan or my eligibility for benefits will not be affected if I do not sign this authorization.

_____ _____

Patient/Parent/Guardian Signature[1] **Date**

_____

Patient Street Address

_____

Patient City, State, Zip

[1] Signature of the person legally authorized to sign for patient, guardian or parent