SPEECH SUPERSTARS
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Authorization for Release and Disclosure of Protected Health Information

Patient Name: _____ Patient DOB:_____

This form is used to release or disclose Protected Health Information as required by state and federal laws. Your authorization allows the release of your child's Protected Health Information to the individual or organization that you choose.

I authorize Speech Superstars to release to/ or obtain Protected Health information to/ from the following:

Name:_____Relationship:_____ Phone:_____

Name:_____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

- ☐ Complete Records: Any and all personal and protected health information

Check all that apply:

- ☐ Evaluation Reports
- ☐ Billing Records
- ☐ Treatment Notes
- ☐ Discharge Summary
- ☐ Plan of Treatment
- ☐ Other_____
- ☐ Attendance Log
- ☐ Progress Summary

The purpose of this release of information:

- ☐ Provide continuity of patient care
- ☐ Educational
- ☐ Coordinate Treatment
- ☐ Personal Use

The consent form may also allow personal and protected health information to be shared via a telephone call with the individual or organization being authorized.

Your authorization is voluntary and may be revoked at any time by submitting a request except when the submission of medical records have already taken place in response to this authorization.

The authorization will expire on_____. If no date is noted, this authorization will expire in twelve (12) months from the date it was signed.

I authorize the use or disclosure of personal and protected health information for my child described above to the individual(s) or organization(s) identified above. I understand that once the information is disclosed per this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

_____	_____	_____
Child's Name	Signature of Parent	Date