Speech4Kids

(352) 240-3155
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www.speech4kidsgainesville.com

13577 NW 2nd Lane
Suite 30
Newberry, FL 32669

Patient's Name: _____ **Date of Birth:** _____

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, _____ (patient/patient's guardian), authorize a mutual exchange of information about the above mentioned patient between the SLP at Speech4Kids of Gainesville and the following recipient(s):

_____ _____
Name Contact information

_____ _____
Name Contact information

This information includes, and is not limited to, medical records, therapy notes/reports, academic records, counseling information and other pertinent information used solely for the facilitation of services rendered to the above-named individual. I have reviewed and I understand this authorization.

Note: If we are requesting this authorization from you for your own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization.
- You may inspect a copy of the protected health information to be used or disclosed.
- You may refuse to sign this authorization
- We must provide you with a copy of this authorization.
- You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization. Unless revoked earlier or otherwise indicated, this authorization will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
Signature of Parent/Guardian Date

_____
Relationship to Patient