TALK
Speech & Language Therapy

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____
Dates of Service: _____

I hereby authorize the disclosure of protected health information as follows:

ORGANIZATION SENDING INFORMATION:
TALK Speech & Language Therapy, LLC
690 Miami Circle NE
Suite 680
Atlanta, GA 30324
770-302-6902

TYPES OF RECORDS TO BE RELEASED:
Verbal discussion with school administrators, teachers, other school personnel, or doctors related to the above client's Speech-Language Therapy is authorized. No written records will be transferred from this office. Verbal discussion is authorized regarding the above client's :

- Speech/Language Strengths and Needs
- Speech/Language Treatment Plan
- Speech/Language Evaluation
- Speech/Language Progress Reports

RECORDS TO BE RELEASED TO:

Organization: _____
Address: _____
_____
Phone: _____

By signing this release I acknowledge:

1. This information is protected under federal law.
2. I may refuse to sign this authorization.
3. I have the right to revoke this authorization in writing.
4. I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.
5. Treatment or payment will not be based on my signing this authorization.
6. I will receive a copy of this authorization if I request it.

_____ _____
Signature of Client or Guardian Date