



**FAMILY SPEECH & THERAPY SERVICES**

**CONSENT TO RELEASE PRIVATE DATA**

Name of child: \_\_\_\_\_

DOB: \_\_\_\_\_

I hereby authorize **Family Speech & Therapy Services** to use or disclose health information about my child. The use or disclosure shall be limited to the information, persons, purposes, and timeframe described below.

**Information to be used or disclosed**

I authorize the use or disclosure of the following protected health information created from \_\_\_\_\_ (date) to \_\_\_\_\_ (date).

**Speech-Language Records and/or Occupational Therapy Records**

I hereby authorize **Family Speech & Therapy Services** to release information to and obtain information from:

**Fax Reports**

\_\_\_\_\_  
School

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Other

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Caregiver (ex. PCA, grandparent, family member)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Address

I understand that I may change this authorization at any time.

\_\_\_\_\_  
Parent /Guardian Signature

\_\_\_\_\_  
Date