A TO Z SPEECH THERAPY

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Medical Information Release Form (HIPAA Release Form)

Name:_____ Date of Birth:_____

Please initial next to the following:

____ I acknowledge that A to Z Speech Therapy has provided me with a notice of their privacy practices.

____ I have read and understand the notice of privacy practices.

Signed:_____Date:_____

Witness:_____Date:_____

Release of Information

Please check one of the following:

[ ] I authorize the release of information including the diagnosis, records;

examination rendered to me and claims information. This information may be

released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed:_____Date:_____

Witness:_____Date:_____