MEDICAL RECORDS RELEASE FORM AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I, _____, of _____,

(Parent/guardian) (City/state)

parent/guardiang of _____date of birth: _____ hereby authorize

(Client name) (Client date of birth)

MLG Speech Therapy to use, disclose and/or discuss the following protected health information listed below from my medical records. I understand the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting confidentiality.

2. Persons or entities with whom MLG Speech Therapy may disclose/discuss your Protected Health Information: (Releasees- i.e. Doctors, Dentists, Therapists, Schools/Teachers, etc.) Name / Title Address Contact information (phone and/or email)

Name/Title	Address	Contact information (phone or email)

3.MLG Speech Therapy is authorized to disclose/discuss the following information, including but not limited to: medical records; treatment records (progress notes, daily session notes); speech, language, academic, and/or swallowing test results; and evaluations/therapy progress as it relates to therapy/treatment and evaluations at MLG Speech Therapy.

4. This information is being used or shared for medical, insurance, legal, and/or educational purposes.

5. I understand that I may revoke this authorization at any time by requesting such of MLG Speech Therapy, in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

_____

Parent/Guarantor Signature

Date _____