



# Children's Speech & Language Services

## Authorization for Release of Information

1) Client name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

2) I, \_\_\_\_\_, parent of \_\_\_\_\_

give my authorization for Children's Speech and Language Services of Springfield, LLC to exchange information about my child with:

Name:

Name:

Address:

Address:

Phone/Fax:

Phone/Fax:

This information is to be released for the purpose of:

This information is to be released for the purpose of:

3) I authorize the individual(s) listed above to use or disclose the following information: *(please check all that apply)*

Assessment and termination summaries.  Progress notes.

Speech and/or Language evaluation(s), reports, assessments, treatment plans and notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations and checklists completed by any staff speech-language pathologist of Children's Speech and Language Services of Springfield, LLC

Social, family, educational, and vocational histories.  Billing records.

4) I authorize sharing this information via: \_\_\_\_\_ phone call, \_\_\_\_\_ e-mail, \_\_\_\_\_ written correspondence

5) Dates of care included:

From: \_\_\_\_\_ to \_\_\_\_\_

6) **I understand that the duration of consent shall be no longer than 365 days.** I understand that after that date, no more of this information can be used or released to the person or organization unless I sign a new Authorization for Release of Information form.

7) I have been provided with a copy of the Notice of Privacy Practices from Children's Speech and Language Services of Springfield, LLC

8) I understand that I can revoke or cancel this Authorization for Release of Information at any time by submitting a written request to the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received, but cannot change the fact that some information may have been sent or shared before that date.

9) I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed.

10) I understand that I may inspect and have a copy of the health information described in this authorization.

11) I affirm that everything in this form that was not clear to me has been explained; I now understand all of it.

**Children's Speech and Language Services of Springfield, LLC**

6354 Rolling Mill Place, Suite 103 ♦ Springfield, Virginia 22152

Phone: (703) 866-0344 ♦ Fax: (703) 866-0233 ♦ [www.cslstherapy.com](http://www.cslstherapy.com)

Please complete all blank areas on this release prior to signature.

Print name of child: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian (if applicable):

\_\_\_\_\_

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Legally-Authorized Representative (if applicable):

\_\_\_\_\_

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of witness:

\_\_\_\_\_

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

**If you do not want any information identified in #3 of this form released to anyone, please:**

- 1. fill out your child's name and date of birth on page 1**
- 1. check the box below**
- 2. sign and print parent name below**

***I choose to not have information released regarding my child***

\_\_\_\_\_  
**Parent signature**

\_\_\_\_\_  
**date**

**Parent name printed:** \_\_\_\_\_

A photocopy of this completed release is considered to be as valid as the original.

**Children's Speech and Language Services of Springfield, LLC**

6354 Rolling Mill Place, Suite 103 ♦ Springfield, Virginia 22152

Phone: (703) 866-0344 ♦ Fax: (703) 866-0233 ♦ [www.cslstherapy.com](http://www.cslstherapy.com)