Children's
Speech & Language Services

Authorization for Release of Information

Client Name: _____ Date of Birth: _____

I, _____, parent of the above name child, authorize the following:

YES	NO	
		I authorize Children's Speech and Language Services, Inc. (CSLS, Inc.) staff to provide speech therapy and/or feeding therapy services to the minor client named above, and named in the attached forms, while I am not present.
		I authorize my child's therapist to email all evaluations, progress updates, daily treatment notes and other information to me at the following email address: _____.
		I authorize CSLS, Inc., in the event of injury, illness or other emergency, when I cannot be contacted, to administer the necessary medical treatment to my child. This treatment may include, but is not limited to, the following: cold packs, general first aid, CPR, EMT, ambulance services, arranging transportation and/or treatment at the nearest hospital emergency room. **
		I authorize CSLS, Inc. release of information to all my insurance companies.
		I authorize CSLS, Inc. to act as my agent in helping me obtain payment from my insurance company.
		I authorize release of CSLS, Inc.'s records and other relevant information to my child's pediatrician, medical specialists, therapists and school personnel by phone call, email and/or written correspondence. *
		I authorize my child's pediatrician, medical specialists, therapists and school personnel to release relevant records and information to CSLS, Inc.by phone call, email and/or written correspondence. *
		I authorize my child's therapist to speak with me about his/her treatment in the waiting room. **
		I authorize any CSLS, Inc. students and/or volunteers to observe my child's therapy session. **
		I authorize a copy of this authorization to be used in place of the original.
		I authorize my spouse and/or _____ to obtain information in my stead. ***(Please indicate the name(s) of nanny, grandparent, caregiver, etc. if someone else will be bringing your child to therapy and you would like the therapist to be able to speak with them.)***
		I understand that the duration of this consent shall be on-going until I contact CSLS, Inc. to revoke or cancel or sign a new Authorization for Release of Information.
		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 CSLS, Inc. staff.
		I understand that I may inspect and have a copy of the health information described in this authorization by requesting a copy from CSLS, Inc.
		I affirm that everything in this form that was not clear to me has been explained and I now understand all of it.

Parent/Guardian Name: _____ Client's Name: _____

Parent/Guardian Signature: _____ Date: _____

***You may/may not (circle one) release records/information to the following:**

****If you answered NO to any of the above questions, please indicate alternatives below and discuss with your therapist.**

Note: This form will need to be updated annually.