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 <u>365</u> 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.

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.

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