



FAMILY SPEECH & THERAPY SERVICES

CONSENT TO RELEASE PRIVATE DATA

Name of child: _____

DOB: _____

I hereby authorize **Family Speech and Language Services** to use or disclose health information about my child. The use or disclosure shall be limited to the information, persons, purposes, and timeframe described below.

Information to be used or disclosed

I authorize the use or disclosure of the following protected health information created between ___/___/___ and ___/___/___ about my child.

Speech and Language Records

I hereby authorize **Family Speech and Language Services**

_____ to release information to:

_____ to obtain information from:

Name

Title

Organization

Address

City

State

Zip code

Phone number

Fax number

I understand that I may change this authorization at any time.

Parent Signature

Date