SUPREME SPEECH
THERAPY FOR ADULTS

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Medical Records Release Form

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I, _____, hereby authorize Supreme 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 Supreme Speech Therapy may disclose/discuss your Protected Health Information:

Name / Title_____

Address_____

Contact information (phone and/or email) _____

3. Supreme 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, cognitive, voice and swallowing test results; and evaluations/therapy progress as it relates to therapy/treatment and evaluations at Supreme Speech Therapy.

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

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

Patient Name _____ Patient Signature_____ Date_____