CENTER FOR COMMUNICATION

Speech-Language Pathology and Literacy Services

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PATIENT AUTHORIZATION TO OBTAIN & RELEASE INFORMATION

(This form allows the Center For Communication to obtain & release information on your behalf)

Client Name: ______________________________________ Date of Birth: _______________

Address: ____

____

Phone #: ____

I give permission for the Center for Communication to obtain & release information from:

Physician/Agency: ____

Address: ____

____

Phone #: __________________________ Fax #: ______________________________

My signature below indicates I understand the purpose of obtaining and/or releasing protected information is to carry out appropriate therapeutic evaluation and services for the client. I understand I may revoke this authorization in writing, at any time. I understand that a revocation is not effective when the Center For Communication has already relied on the use or disclosure of the information provided from this authorization.

Signature: ________________________________ Date of signature: ____________________

Relationship to client (please check one): _____ Self _____Parent _____ Guardian

This release expires one year from date of signature.