Release of Information

Child's Name: _____ Date of Birth: _____

I consent and agree that Patricia M. Weiss, SLP may contact me, leave voice messages, send me text messages and/or send me emails to the phone number(s) and email address(es) I have provided. I understand that these messages can include protected health information, such as patient name, appointment information, billing information, information that identifies the practice as a speech therapy practice, and any pertinent clinical information. I understand that text messages and emails are not secure forms of communication, and that by consenting to these communication types, I am waiving my rights to secure electronic communications. Patricia M. Weiss, SLP may send me informative emails that contain newsletters, information about treatment alternatives or other health related benefits.

I hereby authorize and request that copies of my prior medical records related to speech-language pathology evaluation or treatment services be delivered to Patricia M. Weiss, SLP to establish or continue my health care treatment plan. This includes the complete assessment, most recent plan of treatment, progress summary, treatment notes and any other appropriately related documents or information.

I understand that for the purpose of continuing and coordinating my plan of treatment Patricia M. Weiss, SLP may be asked to release copies of my medical records, or such portions thereof as may be relevant to speech language pathology evaluation or treatment services, or reports or summaries thereof, to other health care providers, facilities (related school or daycare staff, case managers, school system, CDSA, etc.) and appropriately related professionals involved in my care. My signature below indicates that I hereby authorize the release and disclosure of my protected health information to the following people on an as-needed basis as determined by Patricia M. Weiss, SLP (choose all that apply):

Release to other Entity or Individual:

Physician ☐ School Staff ☐ Daycare Staff ☐ Staff Child Care Provider ☐
Related Professional Service Providers ☐ Attendant ☐ Family Member ☐
Custodial ☐

This authorization will EXPIRE upon my discharge from patient services or upon my written request to deny future releases.

Any individuals or entities that I do NOT want to my health information released to are listed specifically below:

_____

Patient/Authorized Representative SIGNATURE

I have read and fully understand the content of this consent and authorization release and hereby agree to and authorize the foregoing provisions. As used in this document, the terms "I", "me" and "my" refer to and include, in addition to the undersigned, the patient named above and other for whom the undersigned is responsible or for whom the undersigned has assumed responsibility engaging with Patricia M. Weiss, SLP to provide services to the patient. This consent and authorization is valid until revoked by me in writing.

Parent/Guardian Signature: _____ Date:_____
Parent/Guardian Printed Name: _____