SPEECH WINGS
THERAPY

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Authorization for Release of Information

I give Speech Wings, LLC permission to use or share my health information with:

_____

The information that will be used or shared includes (check all that apply):

My medical records

My treatment records (progress notes, daily records)

My speech, language, or swallowing test results

Other:_____

This information is being used or shared because:

_____

This authorization will expire:

On _____ (date)

After the following event happens: _____

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time. I need to write to [name of person receiving request] at [address] to do this.
- Any information that was used or shared before I took back the authorization cannot be returned.
- The person or organization that gets my health information because of this authorization may have the right to share it with others without my permission.

_____ _____

Print Patient's Name Date

_____ _____

Patient or Parent/Guardian Signature Relationship to Patient