



Authorization for Release of Information

Consent to Obtain or Release Records
Health Insurance Portability and Accountability Act

I hereby give **The Center for Speech and Language** permission to discuss my case with the interdisciplinary professionals involved in my care, and to release any relevant clinical information to those professionals if requested. I also authorize **The Center for Speech and Language** to release and/or share any information requested by my insurance company.

Client's Name

Persons/Organizations providing/receiving this information:

Name: _____
Organization: _____
Address: _____

Name: _____
Organization: _____
Address: _____

Phone: _____
Fax: _____
Additional comments: _____

Phone: _____
Fax: _____
Additional comments: _____

Signature (Parent/Guardian if client is a minor)

Date

Printed name

Relationship to Client