Talk · Play · Learn | Speech Therapy
2100 SE Lake Rd, Suite 2A
Milwaukie, OR 97222
P: 503-852-1375 F: 503-893-3063

Authorization for Release of Information

I authorize the following provider(s) to use and/or disclose protected health information regarding:

____ (Client/Child name) ___________________________ (Date of Birth)

Name, address, phone number, and fax number of health care provider, individual, or educational program authorized:

Talk Play Learn Speech Therapy 2100 SE Lake Rd 2A Milwaukie, OR 97222 Phone: (503) 852-1375 Fax: (503) 893-3063	Name: ____ Address: ____ ____ Phone: ____________________ Fax: ____________________
☐ send/disclose protected health/educational information ☐ receive/use protected health/educational information	☐ send/disclose protected health/educational information ☐ receive/use protected health/educational information

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

☐ medical records
☐ treatment records (progress notes, daily records)
☐ speech, language, or swallowing test results
☐ IEP/IFSP document
☐ Other: ____

By initialing the spaces below, I authorize the use/disclosure of the following information:
______ Alcohol/Drug Treatment
______ Mental Health Information
______ HIV/AIDS-Related Information
______Genetic Testing Information
______ Other: (please explain) ______________________________

This information is being used or shared for the purpose of:

____

This consent will automatically expire in one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event__ _________________________

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, including this form.
- I may revoke this authorization at any time by notifying Talk Play Learn Therapy in writing. Any information that was used or shared before I revoked the authorization cannot be returned.
- Federal privacy rules for protected health information apply only to health plans, health care clearninghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals, then the disclosed information may no longer be protected by general privacy regulations.

_____________________________________ Print Parent/Guardian or Adult Client Name

_____________________________________ Relationship to Client

_____________________________________ Parent/Guardian or Adult Client Signature

_____________________________________ Date