Wyoming Speaks Speech
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MEDICAL RECORDS RELEASE FORM
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I, _____, of _____, parent/guardian of
(Parent/Guardian) (City, State)

_____date of birth: _____ hereby authorize yoming Speaks Speech Therapy P.C. to use, disclose
(Client Name)

and/or discuss the following protected health information listed below from my medical records. I understand the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting confidentiality.

2. Persons or entities with whom Wyoming Speaks Speech Therapy P.C. may disclose/discuss your Protected Health Information: (Releasees- i.e. Doctors, Dentists, Therapists, Schools/Teachers, etc.)

Information to Be Released:

☐ Medical History
☐ Therapy Evaluation
☐ SLP ☐ OT ☐ PT ☐ Other: _____
☐ Treatment Notes
☐ SLP ☐ OT ☐ PT ☐ Other: _____
☐ School Records (Evaluations, IEP, academic reports, etc.)

Name / Title	Address	Contact information (phone and/or email)

CFv3H; Speaks Spe ech Therapy P.C. is authorized to disclose/discuss the following information, including but not limited to: medical records; treatment records (progress notes, daily session notes); speech, language, academic, and/or swallowing test results; and evaluations/therapy progress as it relates to therapy/treatment and evaluations at yoming Speaks Speech Therapy P.C.

4. This information is being used or shared for medical, insurance, legal, and/or educational purposes.

5. I understand that I may revoke this authorization at any time by requesting such of yoming Speaks Speech Therapy P.C. in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

_____ _____
Parent/Guarantor Signature Date

_____ _____
Parent/Guarantor Name (Printed) Client Name (Printed)