AUTHORIZATION TO EXCHANGE/OBTAIN/RELEASE PROTECTED HEALTH INFORMATION

1. Patient's Name: ________________ Date of Birth: ______________ Date: _________

Address: ____ SSN: __________________

City/State/Zip: _______________________________________

2. RELEASE BETWEEN: ________________________ AND __________________________

Office Name:	Office Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

3. Information To Be Released/Exchanged/Obtained:

- ❏ Speech Evaluation/Treatment
- ❏ Other Therapy Records
- ❏ Evaluation Results
- ❏ Occupational Therapy Records
- ❏ Vision/Hearing Screening/Test Results
- ❏ Other (specify): ________________________
- ❏ Medical Records
- ❏ Referral Information
- ❏ Admission/Discharge Summary
- ❏ Physical Therapy Records

I request the following information **not** be released/exchanged: ___________________

4. Reason for Release/Exchange

- ❏ Coordinate Services between providers
- ❏ Coordinate Care with patient's physician
- ❏ Other: __________________________

5. Expiration

This authorization will expire on _____ / ______ / _______. If I do not indicate a date, this will expire one year from the date of my signature below.

I authorize the use and/or release of my protected health information in order for agencies/practices providing services to better inform care. I understand that I have the right to revoke this authorization at any time by notification in writing and that any information shared prior to revoking this authorization will not be affected by a revocation.

I understand that once released, my information may be disclosed and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA). I understand that Uplift Speech Therapy Services follows all HIPAA rules/regulations and only shares information with person(s) and/or agencies/practices named in this form. Uplift Speech Therapy Services password protects all electronic records and keeps paper documentation locked in a file cabinet. Uplift cares about your medical and personal privacy and does everything possible to maintain your privacy.

6. Signature

I understand that signing this authorization is not a condition of receiving future medical treatment or services. I am confirming my authorization that Uplift Speech Therapy Services may use and/or disclose to the person(s) and/or agencies/practices named in this form the protected health information described in the form.

Signature: ________________________________ Date ____________________