AUTHORIZATION TO DISCLOSE OR RECEIVE INFORMATION

CLIENT NAME: _____ DOB: _____

I hereby give my permission for SPEECH, LANGUAGE AND EDUCATIONAL ASSOCIATES to give and to obtain information from the following individual(s) and/or institutions:

NAME ADDRESS PHONE NUMBER

Pediatrician: _____

_____

School: _____

_____

Other: _____

_____

This authorizes provider to furnish records and information pertaining to medical, mental or physical condition, services and/or treatment rendered. Disclosure shall be limited to the following:

☐ Diagnosis
☐ Discharge Summary
☐ IEP
☐ Medical Records
☐ Mental Health/Behavioral Reports
☐ Results of District Assessments
☐ Speech/Language Information
☐ Other _____

The requestor may use the records and type of information authorized only for the following purposes:
☐ Educational Planning
☐ Other

This authorization shall become effective immediately and shall remain in effect for one calendar year.

I have received a copy of this authorization for my records. A copy of this authorization is as valid as the original.

_____ _____ _____
Signature of Parent/Guardian/Legal Representative Relationship Date

_____ _____
Person securing authorization Date