AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _________________________ (circle: parent, legal guardian, executor, next of kin) give permission to Lakeshore Speech Therapy, LLC to:

☐ Release to ☐ Receive from

Name of person/Doctor/Hospital/Facility: ______________________________

Street: ________________________ City: ____________________

State: ________ Zip: ___________

Phone: ( ) ______________________ Fax: ( ) ______________________

Information to be released:

☐ Discharge Summary ☐ History & Physical

☐ Radiology Report ☐ Other

☐ Evaluation ☐ Goals/Plan of Care

Dates of Treatment: ____

Purpose of Disclosure:

☐ Continuity of Care/Follow-up ☐ Insurance

☐ Legal ☐ Other

Patient Name: ________________________________

SSN: ____

Date of Birth: _______________________________

Phone Number: _______________________

Current Address: ____