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: ____

I hereby authorize Lakeshore Speech Therapy, LLC and its employees to release or receive any and all information contained in my patient records. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses.

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent is valid for 90 days unless otherwise specified. The question of privacy between Lakeshore Speech Therapy, LLC, my attending physician/s, and myself is waived.

Access to medical information is the right of every patient, duplication and distribution is a service. As a professional courtesy, no cost is assessed for information released directly to your health care provider. All other releases are subject to cost for copying and distribution.

Print Name: ____

Signature: ____ Date _________________________

(Patient, Guardian, Administrator, Executor, or Next of Kin-circle one)

Lakeshore Speech Therapy, LLC/ 815 Crocker Rd., #3/ Westlake, OH 44145