RELEASE OF INFORMATION

I, _________________________________ (Parent/Guardian), authorize Lakeshore Speech Therapy, LLC to release to/receive from:

Name of Person/School/Medical Facility or Medical Personnel:

____

Phone: _______________________ Fax: ____________________________

Information to be released:

_____Evaluation/Progress Report _____Discharge Note

_____Goals/Plan of Care _____Other Information

Purpose of Disclosure:

_____Continuity of Care/Follow-up _____Insurance

_____Legal _____Other

I hereby authorize Lakeshore Speech Therapy, LLC and its employees to release or receive from any and all information contained in my patient records.

This consent is subject to revocation at any time in writing except to the extent the action has been taken thereon. Authorization and consent is valid for 2 years unless otherwise specified. The question of privacy between Lakeshore Speech Therapy, LLC and myself, is waived.

Print Name: ____

Signature: _______________________________________Date_________________

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

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