RAINBOW SKIES SPEECH-LANGUAGE THERAPY, LLC

AUTHORIZATION TO RELEASE INFORMATION

I, ________________________, hereby authorize, Rainbow Skies Speech-Language Therapy, LLC
(Parent/Guardian)
to use, disclose and/or discuss protected health information from my medical record to those listed below. I understand the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting confidentiality.

Name/Title	Address	Phone	Email

Rainbow Skies Speech-Language Therapy, LLC is authorized to disclose/discuss the following information, including but not limited to: medical records, evaluation results, and treatment records (i.e. progress notes, daily session notes) as it relates to therapy/treatment and evaluations at this practice. This information may be used or shared for medical, insurance, legal, and/or educational purposes.

I understand that I may revoke this authorization at any time by requesting to Rainbow Skies Speech-Language Therapy, LLC in writing.

____________________________________ ____________________________________
Parent/Guardian Signature Date

____________________________________ ____________________________________
Parent/Guardian (Printed) Client Name (Printed)

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