

Authorization to Disclose Information to Beyond Therapy (Corrective Speech and Language Therapy, Inc.)

Release Form

I voluntarily authorize and request the release of all of _____ (child's name) medical records and other information related to treating and performing necessary tasks. This includes specific permission to release:

1. All records and other information regarding any treatment, hospitalization, and outpatient care for _____ (child's name).
2. Copies of any medical or educational tests or evaluations, including individualized education plans, triennial assessments, psychological, speech and language, occupational, physical therapy evaluations, and any other records that can help evaluate function and assist in treatment.

Information and records may be obtained from and/or released to:

- ALL medical sources including hospitals, clinics, labs, physicians, psychologists, etc.
- All educational sources including schools, teachers, records administrators, counselors, etc.
- Social workers/rehabilitations counselors
- Therapists
- Others who may know about condition (family, neighbors, friends)

* I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.

* I understand that there are some circumstances where this information may be redisclosed to other parties.

* I may write to Beyond Therapy and my sources to revoke this authorization at any time.

* Beyond Therapy will provide me with a copy of this release form if asked; I may ask the source to allow me to inspect or get a copy of the material being disclosed.

***I have read this form and agree to the disclosures above.**

INDIVIDUAL authorizing disclosure:	Relationship to child:
SIGN ► _____	_____

Date signed	Street address	
Phone Number	City	State Zip

<u>Witness</u>	I know the person signing this form or have witnessed them signing this form:
SIGN ►	