Authentic Speech

**MEDICAL RECORDS RELEASE FORM**
**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

1. I, _____ hereby authorize Authentic Speech to use, disclose and/or discuss the following protected health information listed below from my medical records. 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.

2. Persons or entities with whom Authentic Speech may disclose/discuss your Protected Health Information: (Releasees- i.e. Doctors, Dentists, Therapists, Schools/Teachers, etc.)

| **Name / Title** | **Address** | **Contact information (phone and/or email)** |
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3. Authentic Speech is authorized to disclose/discuss the following information, including but not limited to: medical records; treatment records (progress notes, daily session notes); speech, language, academic, and/or swallowing test results; and evaluations/therapy progress as it relates to therapy/treatment and evaluations at Authentic Speech.

4. This information is being used or shared for medical, insurance, legal, and/or educational purposes.

5. I understand that I may revoke this authorization at any time by requesting such of Authentic Speech in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

_____ _____
Client Signature Date

_____
Client Name (Printed)