Hingham Speech & Language Therapy

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Authorization of Release of Protect or Privileged Health Information

Patient Name:___________________________ **Date of Birth:**________________________
Address:_________________________________ **Telephone:**__________________________

I, __________________________ do hereby authorize **Elizabeth McInnes** to release my child, _________________________'s, protected health information including copies of medical records of care to the following persons at the locations listed below:

Person(s)/Facility/Address

Pediatrician:____

School:____

Insurance Company:____

Other:____

Other:____

I understand that:

1. Information released is on this authorization, if redisclosed by the recipient, is no longer protected by this practice.
2. This authorization will expire in twelve months unless otherwise specified:
   ____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my child's condition to those persons or agencies Listed above.

Parent/Guardian Signature:__________________________________ Date:_______________
Print Name:______________________________