Authorization to Release Records

I give ____

____

permission to use or share the health information of the patient listed below with:

PUPPYLOVE SPEECH THERAPY LLC,
957 Route 33; Suite 12 #306, Hamilton NJ 08690
(V) 609.222.3957 (F) 844.908.1430 (E) puppyslp15@gmail.com

The information that will be used or shared includes (check all that apply):

▢ Medical Records, consultation and test reports & evaluations relating to speech & language;
▢ Education records including 504, IEP, therapy reports and notes, and consultation records;
▢ My Progress Reports
▢ My speech, language, or swallowing evaluation and therapy reports, notes and Plan of Care
▢ Other: ____

This information is being used or shared because: ___________________________________

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This authorization will expire on _________________ (date), or one year from the date signed.

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can revoke this authorization at any time by writing to the name and address above.
- Any information that was disclosed revocation cannot be returned.
- The person or organization that gets my health information because of this authorization may have the right to share it with others without my permission.

____ ___________________________

Print Patient's Name Date

____ ___________________________

Patient or Parent/Guardian Signature Relationship to Patient