AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The Federal HIPPA (Privacy Act) of 2001 was created to protect individuals' identifiable health information.

Subject to my right to amend or terminate this consent as set forth below, I authorize *Sound It Out Speech Therapy* to use and disclose protected health information about me/my child as follows:

1. To carry out evaluation and treatment services, schedule services, process payments, coordinate and refer to other health-related service professionals, and for any other purposes *Sound It Out Speech Therapy* and I agree to in writing.
2. To contact me by:
    a. Calling my home, cellular phone, or other designated phone and leaving a voice message in reference to the items described in Section 1 above.
    b. Mailing to my designated address in reference to the items describes in Section 1 above, where such correspondences shall be marked personal and confidential.
    c. Emailing my designated email address provided by me in reference to the items described in Section 1 above.
3. To contact third parties involved in my or my child's care, such as insurance companies, specialty physicians, schools, other parents and legal guardians and other licensed professionals rendering services to my child by:
    a. Calling them and leaving a voice message in reference to the items described in Section 1 above.
    b. Mailing them in reference to the items describes in Section 1 above, where *Sound It Out Speech Therapy* shall identify that such communications contain confidential and protected information.
    c. Emailing them in reference to the items described in Section 1 above.

I may specifically restrict the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date by providing a written statement to *Sound It Out Speech Therapy*. However, (i) I understand that by limiting or revoking *Sound It Out Speech Therapy*'s ability to share such information may restrict or inhibit *Sound It Out Speech Therapy*'s ability to provide its services, process payments, make referrals and coordinate services for my child and (ii) I understand that any limitation or revocation will not affect information that has already been used or disclosed.

I have the right to receive a copy of this consent.

I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I am signing this authorization voluntarily and treatment, payment, and eligibility for benefits will not be affected if I do not sign this authorization.

_____ Signature of Individual, Parent, or Legal Guardian of Minor Child

_____ _____ Patient's Name and Date of Birth

_____ _____ Printed Name of Signature and Date