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AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ DOB: _____

Street Address: _____ City/State: _____ Zip: _____

I understand this release is voluntary and applies to all programs and services operated under the auspices The Language Lounge. I understand that my *personally identifiable information* (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and/or other applicable state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. **I understand that I may revoke this authorization at any time by notifying The Language Lounge in writing, but if I do, it will not have any effect on any actions taken before receipt of the revocation. This release once signed will remain in effect unless otherwise revoked.**

I hereby authorize The Language Lounge to (check all that apply):

☐ Exchange information with ☐ Release information to ☐ Obtain information from

The following Organization/Individual in regard to the above named patient:

Name of Organization/Individual: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

I hereby authorize this information to be exchanged in the following manner(s):

☐ Verbal only ☐ Written form only ☐ Both verbal and written communication

Description of information to be exchanged / released / obtained (select all that apply):

☐ Education records
☐ Evaluation/assessment/eligibility records
☐ Medical records
☐ Clinical records (including: speech therapy)
☐ **Other: _____**

This information is to be used for diagnostic, treatment planning and continuity of care purposes only.

Signature of Parent or Legal Guardian: _____ Date: _____

Print Name of Person signing form: _____ Relationship to Patient:_____

Records Released by: _____ Date: Released: _____