THE VOZ INSTITUTE

Release of Information Consent

Patient's Name: _____ DOB: _____

"I authorize Voz Speech Therapy to send or receive (circle one) the following information:"

_____ Medical history and evaluation(s)
_____ Developmental and/or social history
_____ Educational records
_____ Progress notes, treatment goals or discharge summary
_____ Other: _____

To/From: _____

Phone Number: _____

The above information will be used for the following purposes:

_____ Planning appropriate treatment
_____ Continuing appropriate treatment
_____ Determining eligibility for treatment
_____ Case review
_____ Updating files
_____ Other:_____

"I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information."

_____ _____

Signature Date

_____

Relationship to Patient