Authorization for Use or Disclosure of Protected Health Information

Patient: ______________________________ Birth Date: ______________________

I hereby authorize Jody Sastry Speech Therapy to use or disclose the above patient's protected health information as described below:

1. I authorize Jody Sastry to release information to the following entities:

☐ Family Physician: Dr. ______________________ at ______________________

☐ School Speech Therapist: ______________________________________ at school named: ____

☐ Other: ____

2. I give Jody Sastry permission to communicate with me via:

☐ email

☐ voicemail

☐ text

Please note: if you authorize the use of email, we cannot guarantee that we can keep your health information protected because this is not a secured method of communication.

I am aware that Jody Sastry Speech Therapy has a notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice prior to signing this consent and that I may request a copy of the Notice if I so desire.

Signed: ____

Print your name: ____

Today's Date: ____

This release is open-ended until I sign a different form indicating other choices, or after 7 years from the above date.