Theresa M. Snelling M.A. CCC-SLP and Associates

Treatment Consent and Release Form

Patient Information

Patient Name _____
Last First Middle

Birth Date _____ **Phone #** _____

_____
Street City State Zip Code

Release of Information

I authorize Theresa M. Snelling and Associates to release and exchange information with the following agencies for the purpose of Speech-Language treatment:

_____ _____

_____ _____

Communication With Health Providers

I further authorize Theresa M. Snelling and Associates to communicate and correspond with the above named child's (patient) primary care provider, other health providers indicated below, and /or their office staff for the purposes of treatment and care coordination. This includes telephone, secure e-mail, fax, or written correspondence.

Name of primary care provider _____
Phone _____
Name of other health provider _____
Phone

Information to Be Released

Copies of any previous developmental assessments, related test results, physician reports, school IEP reports, Birth to 3- IFSP reports, and diagnostic reports.

For the time period of: ___/___/___ to ___/___/___

Release to Use Video

I authorize Theresa M. Snelling and Associates to use photographs and videotape for the purposes of consultation and education of other Speech Pathologists or related professionals. Patient confidentiality will be maintained with only first name of patient presented.

Signature Date

Patient Authorized Representative Authorization

I understand that: (1) My signature on this form is strictly voluntary. (2) I may revoke this authorization at any time in writing, and if I do it will not have any effect on any actions taken prior to receiving the revocation. (3) If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. (4) I may inspect or obtain a copy of the health information that I am being asked to disclose.

Expiration: Without my express revocation, this consent will automatically expire upon termination of services with Theresa M. Snelling and Associates unless otherwise specified.

Specified expiration date (optional) _____

Signature _____ Date _____

Printed Name: _____ Relationship to Patient/Authority to Act: _____

Facility Provider's Signature: Date: