POSITIVE OUTLOOK, INC. SPEECH-LANGUAGE SERVICES
696 MT. ZION ROAD, SUITE 3B, JONESBORO, GA 30236
Phone: 404–381-4108 Fax: 404–381-3043

AUTHORIZATION TO RELEASE SPEECH THERAPY INFORMATION

Patient's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Positive Outlook

Address: 696 Mt. Zion Road, Suite 3B

City: Jonesboro State: GA _____ Zip Code: 30236

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information
For the specific use or
purpose of:(describe in detail) _____

As required by HIPAA Privacy Regulations, protected health information may not be used or disclosed to a third party without patient authorization.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.
I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the issues or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I understand that if I choose not to sign this document, it will not affect my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES THIRTY DAYS AFTER IT IS SIGNED.