onword THERAPY
speech-language pathologists

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS

Patient Name _____ Phone Number (___) _____

Social Security # _____-_____-_____ Date of Birth _____/_____/_____

I do hereby authorize: To release to: ☐ Exchange with: ☐

_____ _____

_____ _____

_____ _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

(Specify dates for each, unless "entire medical record" is listed)

_____ Onword Therapy treatment from (date) _____ to (date) _____
_____ Doctors Progress notes
_____ Lab Reports
_____ X-ray Reports (sinus-chest-CT-MRI, ultrasound)
_____ Correspondence from _____
_____ Letters to doctor/facilities
_____ Operative Reports
_____ Records from other doctors/facilities
_____ Verbal Communication

This information is to be used for:

_____Further Treatment (Date of Appointment _____)
_____ Referral
_____ Disability Claim
_____ Insurance Co.
_____ At my request
_____ Social Services or State Agencies
_____ Second Opinion
_____ Operative Reports
_____ Payment of Insurance claims
_____Other (specify) _____
_____ Legal
_____ Personal Records
_____ Education

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATES HERE:

_____ **Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.**

I authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: _____ (specify date or event) or, if no date or event is specified, 12 months from the date of the signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
(If not the patient, state authority/relationship) Date

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