Associated Speech & Language Specialists, LLC

Shoreview	Maplewood	St. Paul	Plymouth
Phone 651-639-0942	Phone 651-773-3208	Phone 651-225-4558	Phone 763-551-3652
Fax 651-639-1718	Phone 651-783-5612	Fax 651-225-9474	Fax 763-551-1334

Authorization for Release of Information

[ ] I hereby authorize Associated Speech and Language Specialists LLC, to **REQUEST** information FROM:

(Facility name, address and phone #)

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[ ] I hereby authorize Associated Speech and Language Specialists LLC, to **RELEASE** information TO:

(Facility name, address and phone #)

Associated Speech and Language Specialists, LLC (Select Location): Shoreview Maplewood Plymouth St. Paul

Regarding the following patient:

Name: ____Date of Birth: _____________________

Address: ____

Parents Name: ____

Phone: ____

Records to be released:

- Consultative Report
- Evaluation Report
- Progress Notes
- Photographs, digital videos
- Other: ____

Purpose of Release:

- Continuing Care for ongoing treatment
- Insurance
- Other: ____

This authorization is valid for one year from the date signed: ____________.

Statement of Authorization:

- I understand that Associated Speech and Language Specialists, LLC will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any given time by giving written notification to Associated Speech and Language Specialists, LLC. A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is released as specified in this authorization the facility, their employees and my therapist(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure of that information.

____ ____________________

Signature of patient/Legally Authorized Representative Date

---**For Office Use Only**---

Records Released By: ______________________ Date: __________________