REDMOND SPEECH & LANGUAGE
SERVING ALL OF CENTRAL OREGON

Authorization for Release and Disclosure Of Protected Health Information

In accordance with state and regulatory agency requirements, the medical record is the property of Redmond Speech & Language: Total Communication Services, LLC

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

I hereby authorize that my medical information be released to:
ALL MEDICAL SERVICES OR:

_____
_____

FROM:
Redmond Speech & Language: Total Communication Services, LLC
326 SW 7th St, Redmond OR 97756

Please release the following information:

___Initial Evaluation ___Re-evaluation ___Progress Notes ___Plan of Care

___History and Physical ___Discharge Summary ___Psychological Evaluation

___Other (Specify) _____

This information is necessary for the following purpose:

___ Continued Patient Care ___Insurance ___Other (specify) _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to Redmond Speech & Language. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, this authorization will continue until therapy is terminated.

4. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

This information has been disclosed to you from records protected by federal law (42 USCA Sec. 290-dd (2). Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 USCA Sec. 290-dd(2).