CONSENT FOR USE, DISCLOSURE AND/OR RELEASE OF PERSONAL AND HEALTH INFORMATION

PARENT/CARETAKER INFORMATION:

LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO CHILD

CHILD'S INFORMATION:

LAST NAME	FIRST NAME/MIDDLE INITIAL	DATE OF BIRTH
ADDRESS	CITY, STATE, ZIP CODE	PHONE NUMBER

I. PERSON OR AGENCY *REQUESTING* THE INFORMATION:

The persons or agency can request my child's personal, health, and/or education information: (The information to be released is described in Section III below.)

Agency Name: Redmond Speech & Language, LLC

Address: 326 SW 7th St

City, State, Zip Code: Redmond, OR 97756

Agency Contact and Title: Sandra Graham (office manager)

Telephone No.: Sandra: 541-316-8078
Fax No: 888-959-9982

II. PERSON OR AGENCY *PROVIDING* THE INFORMATION:

The persons or agency may release my child's personal, health, and/or education information: (The information to be released is described in Section III below.)

Agency Name:

Address:

City, State, Zip Code:

Agency Contact and Title:

Telephone No.:

III. INFORMATION THAT MAY BE RELEASED:

The persons or agencies marked in Section IV below may view, copy, release and exchange the information or records marked below *(please check all that apply to current and future needs)*. This information may be shared verbally, in writing, and/or by email or fax:

☐ Medical Information, including but not limited to operative, emergency, radiology, consultations, progress notes.

☐ Family Information, including but not limited to size of family, family income, family support.

☐ Developmental Information

☐ Educational Records

☐ Speech/Language Information

☐ Developmental Screening Information

☐ Other:

☐ Other:

SPECIFIC AUTHORIZATIONS:

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment or psychological information (Welfare & Institutions Code, §§5328, et seq)

MY INFORMATION MAY BE USED TO:

1. Increase the type/frequency of services
2. Allow various professionals to understand various elements of development.
3. Allow various professionals to help coordinate medical and non-medical services.

IV. INFORMATION MAY BE EXCHANGED BY THE FOLLOWING PERSONS OR AGENCY(IES):

I know that the service team includes the persons and/or agencies marked below *(Please check all that apply to your current and future needs.)*:

☐ Mental Health Services
☐ Psychologist ☐ Physician/Psychiatrist
☐ Therapist ☐ Social Worker
☐ Case Manager ☐ Other _____

☐ Social Services Agency
☐ Social Worker ☐ Case Manager
☐ Other:_____

☐ Regional Centers
☐ Service Coordinator
☐ Administrative Staff
☐ Family Support Worker

☐ Early Care and Education Center Program
☐ Teacher ☐ Staff
☐ Child Caretaker ☐ Other

☐ School District (specify:_____)
☐ Teacher ☐ School Psychologist
☐ School Counselor ☐ School Administrator
☐ Speech/Language Therapist ☐ School Nurse
☐ Other:_____

☐ Healthcare Services
☐ Primary Health Care Provider ☐ Physician Specialist
☐ Social Worker ☐ Psychologist
☐ Family Support Worker ☐ Other:_____

☐ Family Resource Center
☐ Case Manager
☐ Administrative Staff
☐ Family Support Worker

☐ Other Agency: _____

VOLUNTARY: I know that I do not have to sign this consent form. I can refuse to sign this consent form, and it will not affect the services provided from any of the agencies.

LENGTH OF TIME: This consent will be valid from the date that I sign this form until _____(date). If no date is entered, the form will be valid until revoked in writing.

WITHDRAWAL: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to the person or agency in Section I. The withdrawal will be valid as soon as the person or agency gets my note, but will not apply to information that has already been shared after I signed the consent form.

SHARING OF INFORMATION: I know that my information may be shared more than once by the persons and/or agency(ies) in Sections I and II. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws.

COPY: A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this consent form if I ask for one.

Signature:	Date:
Relationship to patient:	