Texoma Pediatric Therapy Services, LLC

Laurie Nix, M.Ed., CCC/SLP

514 N. Elm Street

Sherman, Texas 75020

Tel (903) 436-4300 | *Fax* (903) 868-2330

www.texomaspeechtherapy.com

Consent to Release Information

I give Texoma Pediatric Therapy Services, LLC permission to use or share my protected health information ("PHI") with the following *(list those with whom you authorize us to share your child's PHI. For instance – your spouse, your primary care physician, any other health professionals involved in your child's care, your child's educational institution, et al)*:

____

____

____

The information that will be used or shared includes *(check all that apply)*:

☐ My medical records

☐ My treatment records (e.g. – progress notes, daily records)

☐ My speech, language, or swallowing test results

☐ Other: ____

The above information is being used or shared because:

____

This authorization will expire:

- On ________ / _________ / ___________ (date)
- After the following event happens: ____

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By signing this form, I understand that:

- I do not have to sign this authorization. I will still be able to receive treatment at this facility even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time. I need to write to Texoma Pediatric Therapy Services, LLC at 514 N. Elm, Sherman, TX 75090 in order to revoke my authorization.
- Any information that was used or shared before I took back my authorization cannot be returned.
- Texoma Pediatric Therapy Services, LLC, the facility receiving my PHI because of this authorization, may have the right to share my PHI with others without my permission.

Patient's Name *[please print]:* ____

Date this Form was Signed: _________ / _________ / __________

Parent/Guardien Signature: ____

Relationship to Patient: ____