Nice Speech Lady, PLLC Name: ______________________________ DOB: ______
4030 Wake Forest Road, STE 349 Raleigh, NC 27609-0010
505-907-1902 (phone)

Please sign and fax back to: 1-833-471-5616 (fax)

Release of Information

(Nice Speech Lady Form, effective 7-15-23)

* Patient's name: ____

* I authorize Nice Speech Lady LLC to: __________ Send __________Receive
the following information:

__________Medical history and evaluation(s)
__________Mental health evaluations
__________Developmental and/or social history
__________Educational records
__________Progress notes, and treatment or closing summary
__________ Speech evaluation and treatment records
__________ Speech evaluation, Reassessment and Discharge Summary only
Other ____

List the dates of service requested: ____

To: ____
From: ____

Company Sending/Receiving (circle one) the Info.: _________________________________
Fax: _________________________Phone: ____
Address: ____

* Your relationship to patient (circle which): Self Parent/legal guardian Other (specify):____________

* The above information will be used for the following purposes:
____Planning appropriate treatment or program ____Continuing appropriate treatment or program
____Determining eligibility for benefits/program ____ Case review ____Updating files ____
Other: ____

I understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I also understand that the info. disclosed to recipients may not be protected under these guidelines if they are not a health care provider covered by state/federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time via written notice, and after this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

____________________________________ ____________________
Signature date

____________________________________ ____________________
Printed name role