Nice Speech Lady LLC

409 N. California St. Socorro, NM 87801
505-907-1902 (phone)
https://nicespeechlady.com/for-patients/

Name: _____ DOB: _____

Release of Information

Please sign and fax back to: 1-833-448-2997

* 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