Clear Speech & Language

www.ClearSpeech.org | Direct: (949) 233-2181 / (909) 367-6747 ¡Se Habla Español!

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

By signing and dating this release of information, I, ______________________________, allow the persons or agencies listed below to share specific information about my case, or that of my child, ______________________________. I understand that this is a cooperative effort by agencies involved to share information that will lead to better utilization of community resources and better cooperation amongst our agencies to best meet my needs. The agencies or agency representative listed below will be sharing information:

Name	Address	Date

This consent to release is valid until the time of discharge, or until otherwise specified, and thereafter is invalid. Otherwise, specify date, event, or condition on which permission will expire:

____

I understand that at any time between the time of signing and the expiration date listed above I have the right revoke this consent.

____
Child's Name | Date of Birth

____
Signature | Date

____
Print Name

____
Adult/Guardian Signature | Date

____
Adult/Guardian Relationship to Child

For Office Use Only:

❑ Signed version filed in chart

____
Vanessa Cisneros M.S., CCC-SLP | Date | Date
Heather Elam B.A., SLPA