



Baileigh Landrum, CCC-SLP  
phone 504-578-0251  
email blandrum30@outlook.com

## Authorization to Release Information

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Authorization

Child's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize Speak Easy Mobile Therapy to use and disclose the protected clinical information regarding evaluation and treatment of the named client to

\_\_\_\_\_ (Physician Name)

\_\_\_\_\_ (School Name)

\_\_\_\_\_ (Other)

This released information may be used by the person or entity I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes I direct. This includes, but does not limit, communication to be exchanged through email with all parties listed above.

I understand that I have the right to revoke this authorization, in writing, at any time.

SLP: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_