SPEECH SPOT LLC
***Children's* Speech Therapy**

2017 Authorization for Use or Disclosure of Protected Health Information

Name: ________________________________ Birth Date: _______________

I hereby authorize Speech Spot LLC to use or disclose the above patient's protected health information as described below. Please check the appropriate boxes.

1. Speech Spot LLC may use or disclose information relating to the patient's care during the following relevant period:

   ❑ All past, present and future periods ❑ From (date) _________ to (date) _________

2. I authorize Speech Spot LLC to release information to the following entities:

   ❑ Family Physician: Dr.______________________________ at ______________________________

   ❑ Please circle: Boise School District / Meridian School District /Eagle School District/ West Ada District

   ❑ Ready Set Go Preschool

   ❑ Other: ____

3. I give Speech Spot LLC permission to communicate with me about my child's speech services via (please check those that apply):

□ email □ text □ voicemail

I am aware that Speech Spot LLC has a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice prior to signing this consent and that I may request a copy of the Notice if I so desire.

STATEMENT OF UNDERSTANDING:
I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Speech Spot LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that unless I revoke this authorization as stated above, this authorization will be based on the date I have specified above. I understand that authorization of the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment from Speech Spot LLC. I have the right to limit the information disclosed. I understand that information used according to this authorization may be disclosed by recipient and may no longer be protected by federal or state law.

____ _________________
Signature of Parent/Guardian Date