Articulate Speech and Language Therapy, LLC
4325 Laurel Street, Suite 100
Phone: 907-569-5665 Fax: 866-839-0425

Release of Information Authorization Form

Patient Name:	
AKA Name(s):	**DOB:**

People and entities I authorize to receive my personal health information (PHI)

Name of person(s) or entity(s):	Contact Information (address, phone, email)

Please list medical practitioner(s), spouse, caregiver(s), guardian(s), etc. you are authorizing to receive your PHI

The purpose for this Release of Information Authorization:

I hereby authorize the use or disclosure of my health care and/or other information within my patient record to the entities stated above and that my records may contain sensitive information. I understand that this authorization is voluntary and that I may revoke this authorization at any time by signing the revocation section at the bottom of this form, or by notifying Articulate Speech and Language Therapy, LLC in writing. I acknowledge that revoking this authorization will not affect actions taken on this authorization prior to the date the revocation was received. I understand that Articulate Speech and Language Therapy, LLC will not condition my treatment, payment, or eligibility for services based on whether I provide this authorization.

I understand that if the person(s) or entities I authorize to receive my protected health information are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipients of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

Signature of Patient or Personal Representative: **(Or witness if signature is by mark)** **Date:**
Printed name of Personal Representative (or witness description of Personal Representative's Authority):
Complete when/if revoked **This authorization was revoked on: _____ (date)** **Signature of Patient or Personal Representative:**

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL