harbor speech PATHOLOGY

hope, healing and recovery

Consent for Disclosure Written and Verbal Communications

I, _____, hereby authorize and request Harbor Speech Pathology or its representatives to:

( ) Release information to ( ) Obtain information from ( ) Exchange information with the following individual(s):

_____

_____

_____

_____

Regarding: _____ Date of Birth: _____

INFORMATION TO BE RELEASED:	YES	NO
Progress reports	_____	_____
Evaluations of treatment participation	_____	_____
Medical history/Social history	_____	_____
Alcohol and other drug history	_____	_____
Psychological/Psychiatric testing, evaluation and reports	_____	_____
Other (specify) _____		
_____	_____	_____

I understand that my records are protected under the Federal (42CFR) and State (RCW 71.05.390) confidentiality Law and Regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically as specified below or in 90 days without such specification. This information released may be obtained via mail, telephone, fax, or in person.

Specification of the date, event, or condition upon which this consent expires:

_____

_____ _____

PATIENT/ GUARDIAN SIGNIFICANT DATE

_____ _____

WITNESS DATE

Harbor Speech Pathology
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