Lambert Speech & Language Services
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Authorization for Use / Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my / my child's individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

___________________________________ Lambert Speech & Language Services ____/_____/_____
(Patient/Client/Resident Name) (Facility / Program) (Date of Birth)

I hereby authorize Lambert Speech & Language Services (LSLS) to release / obtain (circle one) information contained in my / my child's records to / from (circle one) the following individual or organization:

____/______________________________
(Phone Number)
____/ _______________________/_____/___________________
(Address) (City) (State) (Zip Code)

This information is being disclosed for the purpose of coordination of care.

INFORMATION TO BE OBTAINED OR DISCLOSED: (Patient should check all that apply)
Covering the period(s) of health care from: ______________________ to ______________________.
_____ Initial Assessment _____ Treatment Plan/Goals _____ Discharge Summary
_____ Consultation Reports _____ Progress Reports Other: _________________________

I understand that I have the right to revoke this authorization at any time. This does not apply to information that has already been released prior to receiving the revocation.

If not previously revoked, this authorization will expire on _____/ _______/_______, or after 90 days unless otherwise specified (not to exceed one year).

LSLS, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION; HOWEVER, RECORDS CANNOT BE RELEASED WITHOUT YOUR SIGNITURE.

____ _________________________
(Patient / Client/ Resident's Signature) (Date)

____ _________________________
(Parent/Guardian's/Empowered Representative Signature) (Date)

____ _________________________
(Print Name) Parent/Guardian/Empowered Representative (Relationship to child)

____ _________________________
(Witness) (Date)

Prohibition on Redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient.