Simone Hüls, Ph.D., CCC-SLP

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Release/Request to Release Confidential Records and Information

This form, when completed and signed by you, authorizes me to release and receive protected information from your/your child's clinical or educational record with the person or people you designate.

Client Information

Name: _____ Address: _____

Date of Birth: _____ _____

Parent (if minor)_____ Phone: _____

Authorization for Release. I hereby authorize the exchange of information between the following parties:

Simone Hüls, Ph.D., CCC-SLP SP25805
5975 Entrada Ave.
Atascadero, CA 93422
805-858-9222

_____
Name (Person or Facility)

_____
Street Address

_____
City, State, Zip

_____
Phone Fax

Specific Authorization. I specifically authorize the release and/or exchange of the following confidential information:

___ All Records ___ Therapy Records ___ Reports ___ Test Results ___ Clinical Observations
___ Recommendations ___ Therapy Summary ___ Billing Information ___ Other (please specify below)
_____

For the following Purpose(s):

___ At the request of the individual ___ Treatment Planning ___ Change of therapist
___ Speech-Language Testing, evaluation, treatment or referral ___ Other (please specify)
_____

I have had explained to me and fully understand this authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically one year from the date on which it is signed.

_____
Signature of Client / Patient Printed name Date

_____
Signature of parent/guardian/representative Printed name and relationship to Client/Patient Date