Medical Records Release Form

Patient Name:	Date of Birth:

I _____ hereby authorize **Speech Therapy Associates, LLC** to release, use, discuss, and/or disclose speech-language pathology and relevant health and medical information to the entities listed below.

Name/Facility	Address	Phone	Email

I understand that the protected health information will be shared for relevant health/medical, legal, and/or educational reasons. Information may include speech/language assessments or evaluation results, treatment plans, progress notes, medical records, and/or academic information.

I understand that I can revoke my authorization at any time by providing a written request to the office.

I understand that this release form provides additional consent beyond what is outlined in the HIPAA Privacy Notice form, which I have read and reviewed.

Your Signature: _____ Date: _____

Relationship to Patient: _____

Speech Therapy Associates, LLC

121 Webb Drive, Suite 400, Davenport, FL, 33837

Office 863-296-8461 | Email: Speechtherapyassociatesfl@gmail.com