www.SunnyPediatricServices.com
office@sunnyspeech.com
Office Phone: (850) 909-5521 Fax: (850) 391-4178

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Child's Name: _____ Child's Date of Birth: _____

I, _____, authorize the Sunny Speech Inc. to:
(printed name of parent/caregiver)

Please place your initials in the blank in order to give consent to any statement that may apply to your child.

_____ release records to, obtain records from and exchange information with **any and all** healthcare professionals whom my child is currently or has previously been seen by

_____ release records to, obtain records from and exchange information with **only specific** healthcare professionals whom my child is currently or has previously been seen by (indicated below)

Name: _____ Phone Number:_____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

_____ exchange information pertaining to the care and progress my child with any person/s listed below:

Name:_____ Phone number:_____

Name:_____ Phone number: _____

Name:_____ Phone number: _____

_____ communicate information regarding my child and their care through the following:

____ text messages ____ email

____ phone call ____ message left on voicemail

____ all of the above

In order to best serve your child in evaluation/assessment and coordinating treatment, we ask for your permission to exchange information with your child's current and/or previous healthcare providers. Our notice of privacy practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our patient consent form. On occasion, the patient and the practice may want to use (PHI) for the reason other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the Health Information Technology for Economic and Clinical Health Act of 2009 among other laws. The below mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules. We assume no liability for disclosure by the receiving party.

_____ _____
Signature of parent/guardian Date