Tallahassee, FL
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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)

_____ 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)

_____

_____

_____

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