The SPEECH & LANGUAGE Center

1591 Port Republic Road
Harrisonburg, VA 22801
p(540) 437-4226
f(540) 437-4227
info@thespeechandlanguagecenter.com

CONSENT TO RELEASE INFORMATION

By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate my services and/or benefits.

I, _____, am signing this form for _____

(Full printed Name of Consenting Person) (Full Printed Name of Client)

_____.

(Client's Date of Birth)

My relationship to the client is: ☐ Self ☐ Parent ☐ Guardian ☐ POA ☐ Other (explain): _____.

I want the following confidential information about the client to be exchanged:
☐ Any and all healthcare information ☐ Other (explain):_____

I hereby authorize:
The Speech & Language Center, PLLC 1591 Port Republic Rd. Harrisonburg, VA 22801, (540) 437-4226, fax (540) 437-4227
and the following other Agencies to be able to exchange this information:

☐ Infant-Toddler Connection of Harrisonburg-Rockingham
☐ UVA Health Systems
☐ Harrisonburg-Rockingham CSB
☐ Rockingham County Schools
☐ Harrisonburg City Schools
☐ Page County Schools
☐ Shenandoah County Schools
☐ Staunton City Schools
☐ Augusta County Schools
☐ BRAHEC Interpreter Services
☐ PCP: _____
☐ Additional Agencies: _____
_____

Information may be shared:
☐ in writing ☐ in meetings or by phone ☐ electronically (via secure computer-based system)

☐ Email:
I understand that email messages sent by Speech & Language Center staff are not encrypted before being sent. Information sent over the Internet without encryption may be seen by other people while in transit. I understand that my electronic health records will be sent via the secure document portal, WebPT. I agree to have information shared via email.

☐ Video/Pictures ☐ Text/SMS messaging
(if either of these boxes are checked, additional release(s) must be signed)

I want to share additional information received after this consent is signed: ☐ yes ☐ no

I want all agencies to accept a copy of this form as a valid consent to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information they need.

Unless otherwise revoked, the authorization does not expire.

_____ _____
Signature(s) of Consenting Person(s) Date

Consent Revoked on _____ by _____ _____.
Date Print Name Signature