CONSENT TO RELEASE CLINICAL INFORMATION

Laura Donoghue, MA, CCC-SLP and Ann Arbor Speech & Language Therapy Center, LLC is authorized to use, disclose, or discuss the private and protected health information for:

______________________________ ______________
client name date of birth

with the following persons or organizations:

Name: ______________________________

Organization: ______________________________

Phone: ______________ Email: ______________

_____ initials — I am the parent or legal guardian requesting the release of protected health information for the above-named client.

_____ initials — I authorize the use of electronic communication (i.e., email or text messages) to disclose or discuss protected health information to the above-named recipients. I further understand and acknowledge and will not hold Laura Donoghue or Ann Arbor Speech & Language Therapy Center liable for any security risks associated with using electronic communication that is not end-to-end encrypted.

_____ initials — I understand that private health information may no longer be protected by federal or state law should the above-named recipient(s) re-disclose any information that was originally shared under the protection of this authorization.

This authorization remains in effect until the client discontinues speech-language therapy services with Ann Arbor Speech & Language Therapy Center, LLC. Authorization may be revoked by submitting a written request at any time.

______________________________ ______________
Signature Date

______________________________ ______________
Name (print) Relationship to client

This form complies with the Health Information Portability and Accountability Act (HIPAA) of 1996.