Lawrence Speech & Hearing Services

Authorization to Release Medical Records

Patient's Name:____

Date of Birth: ______________________ Social Security Number: _______________________________

Guardian's Name: ____

I request and authorize ____ to release healthcare information of the patient named above to: Lawrence Speech and Hearing Services.

Check All That Apply	
	Healthcare information relating to the following treatment, condition or dates:
	All healthcare information.
	Any records regarding medications, drug, alcohol or mental health treatment to the person(s) listed above.

Patient Signature: ____ Date: _______________

I request and authorize Lawrence Speech and Hearing Services to release healthcare information of the patient named above to:

Check All That Apply	
	The patient's primary health care physician if requested.
	To provide continuing treatment
	To obtain Insurance or Governmental benefits

This request and authorization also applies to the provider: calling me with appointment reminders and other administrative operations.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

Patient Signature: ____ Date: _______________

Witness Signature: ____

Christina Lawrence, Au.D., CCC-A/SLP
Doctor of Audiology, Speech-Language Pathologist & Owner
515 Grand Avenue, Suite E, Mancos, Colorado 81328
Phone: 970-459-1179 Fax: 800-531-0273
Email: lawrencespeechandhearing@gmail.com Website: www.lawrencespeechandhearing.com