SPEECH THERAPY SERVICES, P.C.
502 South Wheat Avenue
Bainbridge, GA 39819
(229) 246-4088 • (229) 246-0205 Fax

AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

NAME_____ DOB:_____

I HEREBY REQUEST AND AUTHORIZE:
NAME:_____

ADDRESS:_____

_____

RELATIONSHIP:_____

TO OBTAIN FROM OR RELEASE TO:
NAME:_____

ADDRESS:_____

_____

_____

RELATIONSHIP:_____

THE FOLLOWING INFORMATION:_____

_____

FOR THE PURPOSE OF:_____

_____

All Information I Hereby Authorize To Be Obtained From/By This Agency Will Be Held Strictly Confidential And Cannot Be Released Again Without My Written Consent. I Also Authorize The Use Of Clinical Observation And Case Discussion For Professional Purposes.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN **DATE**

_____
RELATIONSHIP TO PATIENT

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