Milestones Speech & Language Therapy
Sarah Budney, MS, CCC-SLP

Authorization for Release and Request of Protected or Privileged Health Information

Client/Child Name _____ Client Date of Birth _____

Address _____ Telephone (___)_____

I, _____, of _____certify that I am the parent or legal guardian of the
(Parent/Guardian) (City/State)
child named above. I hereby authorize Sarah Budney, MS, CCC-SLP to release and receive protected information regarding my child's medical history, developmental needs, educational goals, etc. with the following persons at the locations/facilities listed below:

1)_____ _____ _____
(name) (phone) (email)

_____ _____
(facility name) (address)

2)_____ _____ _____
(name) (phone) (email)

_____ _____
(facility name) (address)

3)_____ _____ _____
(name) (phone) (email)

_____ _____
(facility name) (address)

I understand that this authorization will expire upon discontinuation of therapy with Sarah Budney, MS, CCC-SLP, unless specific date of discontinuation specified here _____

I understand that I may refuse to sign or may revoke (at any time) the Authorization for any reason, and that such refusal or revocation will not effect the commencement, continuation, or quality of Sarah Budney's, MS, CCC-SLP's treatment of my child. I hereby release Sarah Budney, MS, CCC-SLP from all legal responsibility or liability that may arise from the release of this information or re-disclosure by the recipients.

I have carefully read and understand the above, have had any question explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my child's condition to those persons or agencies listed above.

Signature of Parent/Legal Guardian _____ Date: _____

Print Name: _____ Relationship to Client: _____