6230 Tenth St., Suite 220
Oakdale, MN 55128
651-739-2300
651-739-2302 fax

Consent for Release of Information

Patient Name:	Date of Birth:
Parent(s):	
Address:	
City, State, Zip	
Social Security Number:	Phone:

I authorize the release of the following records: **I also authorize re-release of reports this agency may have from other providers/schools. ____________(initial)**

- ❑ Speech-Language Evaluation and/or Therapy
- ❑ Occupational Therapy Evaluation and/or Therapy
- ❑ Physical Therapy Evaluation and/or Therapy
- ❑ Educational/Special Education
- ❑ Medical, as related to therapy received in this office only
- ❑ Other

Purpose for record release:

- ❑ Legal
- ❑ Insurance
- ❑ Provider Change
- ❑ Professional Collaboration
- ❑ Continuing Care
- ❑ School
- ❑ Other:

Release:

❑ From X To

Center for Speech, Language and Learning, Inc.
6230 Tenth Street, Suite 220
Oakdale, MN 55128
651-739-2300

Release:

X From ❑ To

____
._______________________________________
____
____
____
____

- I understand that my consent to release records is completely voluntary and may be revoked at any time by providing that directive in writing to this organization.
- In consenting, I understand information obtained is confidential and may be used only for the purposes discussed and may not be released to other requestors without my consent.
- I understand this consent is not required for consideration for services and my health care will not be affected if I do not sign this form.
- I understand I may see and request a copy of information received and that this organization reserves the right to charge me for said copies.
- I have been informed that Center for Speech, Language and Learning, Inc. will not receive financial or other compensation for disclosing the health information described above.

____ __________________________
Parent/Legal Guardian/Patient Date