# Permission to Release and Obtain Information

Client Name: _____ Birthdate: ____ / ____ /_____

Address:_____ City:_____ State:_____ Zip:_____

Parent or Legal Guardian (if applicable): _____

Email Address:_____ Phone:_____

**Email Authorization:** In order to facilitate prompt and efficient communication, I authorize CSHC staff to communicate with me using the e-mail address listed above. I understand that personally identifiable information may be contained in the email communication and I accept the risk of unintentional disclosure or unauthorized attempts (by hackers) to access this information. This permission will be valid until I revoke it in writing.

**Signature:** _____ Date: _____/_____ /_____

**I give permission to CSHC to share/exchange information with:**

Name: _____

Address: _____

_____

Name: _____

Address: _____

_____

**Special restrictions/instructions:**

❒ Release only ❒ Obtain only

❒ No report needs to be sent

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**Signature:** _____ Date: _____/_____ /_____

***I understand and agree that this permission shall remain in full force and in effect for one (1) year unless cancelled in writing. (This form gives general and special authorization to release information which may refer to HIV status and/or drug and alcohol abuse and/or treatment.)***

## Consent

I hereby give my permission to the staff of the Columbus Speech & Hearing Center to carry out all necessary diagnostic, assessment and treatment activities which will address the needs of the above-named client.

**Signature:** _____ Date: _____/_____/_____

Relationship to Client: _____

**Disclosure:** As a courtesy to our clients, the Columbus Speech & Hearing Center will submit claims to any/all insurance companies although the client is ultimately responsible for payment for services. Clients with out-of-network insurance will be responsible for payment in full at time of service.

**Clients are responsible to notify us immediately of any changes in insurance or personal information.**

**Initials:** _____

510 E. North Broadway · Columbus · OH · 43214 · 614.263.5151
614.429.1382 VP · 614.263.2299 TTY · 614 263.5365 FAX
www.columbusspeech.org