



# 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 CSH staff to communicate with me using the email address listed above. I understand that the email communication may contain personally identifiable information, 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 CSH to share/exchange information with:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

## Special restrictions/instructions:

Release only       Obtain only

No report needs to be sent

Release only       Obtain only

No report needs to be sent

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

## CONSENT

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

**DISCLOSURE:** As a courtesy to our clients, Columbus Speech & Hearing 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 the time of service.

**Clients are responsible for notifying us immediately of any changes in insurance or personal information.**

**Initials:** \_\_\_\_\_