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 Columbus Speech & Hearing 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: ____________

510 E. North Broadway
Columbus, OH 43214
Phone (614) 263-5151 | **Fax** (614) 263-5365

5155 Bradenton Ave., Suite 150
Dublin, OH 43017
Phone (614) 263-5151 | **Fax** (614) 261-5790

470 Olde Worthington Road, Suite 470
Westerville, OH 43082
Phone (614) 263-5151 | **Fax** (614) 261-5420

ColumbusSpeech.org