

Release of Health and Educational Information

I GIVE PERMISSION TO:

Cynthia Moore, CCC- SLP
 In Harmony Speech and Language Services
 112 Ipswich Rd
 Boxford, Mass 01921

TO RELEASE INFORMATION TO:

PERTAINING TO:

First Name of Child	Last Name of Child
_____	_____
Telephone Number	Date of Birth 00/00/0000
_____	_____
Address, City, State, Zip Code	

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here ____/____/____

CANCELLATION: This authorization is also subject to written cancellation by the parent/guardian at any time. The written cancellation will be effective upon receipt. Cancellation will not apply to actions taken based on information obtained from prior authorization(s).

RE-RELEASE: I understand that the recipient may not lawfully further use or release the information unless another authorization is obtained from me or unless such use or release is specifically required or permitted by law.

SPECIFIC RECORDS: check the box and initial which type of information is to be released.

Initial	Check	Information	Initial	Check	Information
		Educational			Health and Development
		Speech and Language			Hearing Audiological
		Medical Information			Vision

Print Name _____ Date _____

Parent / Guardian Signature _____

Relationship to Child _____ Child's Name _____