in harmony
Speech, Language and Learning Services

Specializing in the Evaluation and Treatment
of Children with Communication Disorders

Request for Health and Educational Information

I GIVE PERMISSION TO:

____

TO REQUEST INFORMATION FROM:______________________________________
(Name of person or organization allowed to request information)

____
Address, City, State, Zip Code

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 ad 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** ______________________