Speech and Language Services

1540 South 70th Street, Suite 101
Lincoln, NE 68506

Toni B. Morehouse, MA, L-CCC-SLP, BCS-CL, Partner
Email: toni@comworkslincoln.com

Carol A. Bowen, MA, L-CCC-SLP, Partner
Email: carol@comworkslincoln.com

Website: www.comworkslincoln.com
Phone: (402) 480-3152
Fax: (402) 904-7651

# AUTHORIZATION TO RELEASE INFORMATION

Client's Name______________________________ Birthdate______________________________
Address______________________________ City, State, Zip______________________________

## Authorization for Communication Works, LLC to release information:

I hereby authorize Communication Works, LLC to disclose protected health information and other records in its possession to the following health care providers or educational institutions. The information may be disclosed in face-to-face meetings, or via phone conversations, faxes, email messages, or written documents.

Name of Entity, School, or Person______________________________
Address______________________________ City, State, Zip______________________________
Email______________________ Phone______________________ Fax______________________

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Address______________________________ City, State, Zip______________________________
Email______________________ Phone______________________ Fax______________________

Name of Entity, School, or Person______________________________
Address______________________________ City, State, Zip______________________________
Email______________________ Phone______________________ Fax______________________

## Authorization for a Disclosing Party to release information to Communication Works, LLC:

I hereby authorize the Disclosing Party named below to release protected health information and other records in its possession to Communication Works, LLC. The information may be disclosed in face-to-face meetings, or via phone conversations, faxes, email messages, or written documents.

Name of Disclosing Entity, School, or Person______________________________
Address______________________________ City, State, Zip______________________________
Email______________________ Phone______________________ Fax______________________

**Mail or fax records to: Communication Works, LLC • 1540 South 70th Street • Lincoln, NE 68506 Fax: 402-904-7651**

*I certify that I have read and fully understand this Authorization Form. This consent will expire one year after the date signed.*

______________________________ ______________________________ ______________________________
Client Signature Relationship to Client Date of Signature

Persons 18 years of age or younger must have a parent or guardian sign the form on their behalf.

communication...the essential human connection
~Ashley Montagu