communication works
Speech and Language Services
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AUTHORIZATION TO RELEASE INFORMATION

Client's name	Birthdate
Address	City, State, Zip

Authorization for Communication Works to release information

I hereby authorize Communication Works to disclose protected health information (PHI) and other records in its possession to the following entities. The information may be disclosed in face-to-face meetings or via phone conversations, faxes, email messages, written documents, video conferences or other telehealth practices.

Doctor (or referring dentist/orthodontist)	
Name of practice	Phone
Address	City, State, Zip

Teacher	
School	Phone
Address	Email

SLP	
School or agency	Phone
Address	Email

Family member other than parent	
Relationship to client	Phone
Address	Email

Other professional(s)	
Name of agency	Phone
Address	Email

Other professional(s)	
Name of agency	Phone
Address	Email

I certify that I have read and fully understand this Authorization Form. This consent will expire one year after the date signed. Persons 18 years and older must have a parent or guardian sign form on their behalf.

Person signing form	Relationship to client	Date