communication works
Speech • Language • OT • PT
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AUTHORIZATION TO RELEASE PHI

Client's name:	Birthdate:
Address:	City, State, Zip:

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:	
Name of practice:	Phone:
Address:	Fax:
DENTIST:	
Name of practice:	Phone:
Address:	Fax:
ORTHODONTIST:	
Name of practice:	Phone:
Address:	Fax:
SCHOOL or	
PRESCHOOL:	Phone:
Address:	Fax:
SPEECH-LANGUAGE PATHOLOGIST:	
School or agency:	Phone:
Address:	Email:
OCCUPATIONAL THERAPIST:	
School or Agency:	Phone:
Address:	Email:
PHYSICAL THERAPIST:	
School or Agency:	Phone:
Address:	Email:

I certify that I have read and fully understand this Authorization Form.
Persons 18 years and younger must have a parent or guardian sign the form on their behalf.

Person signing form:	Relationship to client:	Date: