Chris Zwolfer, MA, CCC-SLP
Pediatric Speech and Language Services

Authorization for Release of Information

I give Christine Zwolfer permission to use or share my health information with:

_____

The information that will be used or shared includes (check all that apply):

- ☐ My medical records
- ☐ My treatment records (progress notes, daily records)
- ☐ My speech, language, or swallowing test results
- ☐ Other: _____

This information is being used or shared because:

_____

This authorization will expire:

- On _____ (date)
- After the following event happens: _____

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time. I need to write to [name of person receiving request] at [address] to do this.
- Any information that was used or shared before I took back the authorization cannot be returned.
- The person or organization that gets my health information because of this authorization may have the right to share it with others without my permission.

_____	_____
Print Patient's Name	Date
_____	_____
Patient or Parent/Guardian Signature	Relationship to Patient