SUSANNA WEINBERGER
SPEECH AND LANGUAGE

Authorization for Release & Request of Information

I, parent/guardian of _____, hereby authorize **Susanna Weinberger Speech and Language** to **release** his/her past, present, and future treatment records and **request** past, present, and future medical records for the purposes of continuity of care, case management, and billing/reimbursement to/from:

_____

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There is no expiration on this authorization for release/request of information.

I understand that:

- Treatment records are maintained in accordance with the Health Insurance Portability and Accountability Act (HIPPA).
- I may see or copy the health information that will be used or shared.
- I can revoke this authorization at any time.
- I have the right to view my/my child's records at any time.
- Those in receipt of my health information because of this authorization may have the right to share it with others without my permission.

I have read and understand the contents of this consent form.

_____ _____

Client's Name Date

_____ _____

Parent/Guardian Signature Date

Weinberger.Susanna@gmail.com (310)270-5717