THE SPEECH & HEARING CENTER
Caring Professionals
Providing Professional Care

Suite 200
600 North Holtzclaw Avenue
Chattanooga, TN 37404-1240
PH: 423.622.6900
FX: 423.622.4834
www.speechhearing.com

RELEASE OF INFORMATION

Patient's Name: ______________________________ Date of Birth: ____________

Current Address: ____

Telephone Number(s): ____

I hereby give my consent for The Speech and Hearing Center:

☐ To Release To:

(Name and Address of Agency/Person)

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Information Concerning:

☐ Audiological Reports
☐ Therapy Reports/Notes
☐ Other:

☐ Speech/Language Reports
☐ Program Planning/Recommendations
☐ Educational Records

Reason for Request: ____

All of the information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released without my written consent. I understand that I have the right to inspect and copy the information to be disclosed. I understand that I may withdraw this authorization at any time.

This release is effective up to and including six (6) months from the date of signature.

______________________________ ______________________________

Signature of Consenting Party **Relationship to Patient**

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Date

Release Form.doc, Created on 11/13/00 9:02 AM