Bloom & Be
Therapy and Educational Services

Bloom & Be Therapy and Educational Services
(765)273-3279
intake@bloomspeechandlanguage.com

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ Date of Birth: _____

Address: _____

I understand this release is voluntary and applies to all programs and services operated under the auspices of Bloom Speech & Language Services. I understand that my personality identifiable information (PII) may be protected by the federal rules for privacy under the Family Educational Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and /or other applicate state or federal laws and regulations. I understand that my PII may be subject to re-disclosure by the recipient without specific written consent of the person to whom it pertains, or as otherwise permitted. I also understand that the recipient may not condition treatment, payment, enrollment, or eligibility on whether I sign this form, except for certain eligibility or enrollment determinations. I understand that I may revoke this authorization at any time by notifying Bloom Speech & Language Services in writing, but if I do, it will not have any effect on any actions taken before receipt of the revocations. This release once signed will remain in effect unless otherwise revoked.

I hereby authorize Bloom & Be Therapy and Educational Services to (check all that apply):
__ Exchange information with ___ Release information to ___ Obtain information from

The following Organization/Individual in regard to the above named patient:
Name of Organization/Individual: _____
Address: _____

Description of information to be exchanged/released/obtained (select all that apply):
___ Education Records
___ Evaluation/assessment/eligibility records
___ Medical Records
___ Clinical Records (including behavior analytic, psychological, physical, occupational, and speech therapies)

This information is to be used for diagnostic, treatment planning, and continuity of care purposes only.

Signature of Parent or Legal Guardian: _____ Date: _____

Print name of person signing form: _____

Relationship to patient: _____