The Speech and Swallowing Clinic, LLC DBA

The Therapy Tree

912.331.0846 Phone 912.331.0847 eFax

MEDICAL RECORD RELEASE REQUEST

Patient Name:_____ **DOB**:_____ **SSN**:_____

The following facility and or individual is authorized to make the disclosure:

Facility/Individual:_____

Address:_____

Phone:_____ Fax:_____

The following information is authorized to be released:

_____Full Medical Record _____
_____IEP/IFSP _____
_____All Speech Pathology Record (s) _____
_____All Occupational Health Record (s)_____
_____All Behavioral Health Record (s) _____
_____Hearing Screening from birth
_____Discharge Summary _____
_____All Patient History & Physical _____

I understand that my health record may include information relating to the treatment of communicable diseases, confidential medical diagnosis, and/or behavioral or mental health services, and the treatment of such diseases, diagnosis and services.

This information may be disclosed and used by the following group and/or facility:

The Therapy Tree
All Locations
Phone: 912-331-0846 eFax: 912-331-0847

I understand that authorizing the disclosure of this health information is voluntary.

Signature of Patient/Guardian:_____ **Date**:_____

Legal Representative:_____ **Date**:_____