Autism Clinic
SPEECH THERAPY & TRAINING CENTER
JOIN • PLAY • GROW

2552 E. Kenosha St.
Broken Arrow, Ok 74014
918-893-3735 Fax 918-893-3745
Stephanie Barton M.Ed. CCC-SLP
Lori Frederick, Executive Director

RELEASE OF INFORMATION REQUEST

Dear Parent:

Please sign and send one copy of this release form to your pediatrician, and any other therapist or health care provider treating your child. Please feel free to make as many copies of this form as you need. We need at least one form completed for your primary care physician and one for the professional who referred your child to us, so that we may share information regarding our assessment and treatment. Thank you.

Dear Health Care Professional:

The patient named below is going to be seen at ***The Griffin Promise Autism Clinic*** for an evaluation and/or treatment. We would appreciate receiving a copy of your records regarding your client to assist in our comprehensive review and assessment. If the child is going to be seen for a feeding problem, we would especially appreciate a copy of the growth curve or any other relevant reports be included with your records. Below is a release to be signed by the child's guardian. If you have already sent this information as a part of your referral, please disregard this request

Patient's Name: _____ **Date of Birth:** _____

Guardian's Name: _____ **Relationship:** _____

I HEARBY AUTHORIZE THE FOLLOWING HEALTH CARE PROFESSIONAL TO RELEASE COMPLETE INFORMATION FROM THE MEDICAL, SCHOOL, SOCIAL SERVICE AND/OR PSYCHOLOGICAL RECORD OF THE ABOVE NAMED CLIENT/PATIENT TO:

The Griffin Promise Autism Clinic
Fax 918-893-3745

I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that treatment, payment, or eligibility of benefits can not be conditioned on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Name of Health Care Professional: _____

Address: _____

Phone Number: _____

GUARDIAN/CLIENT SIGNATURE: _____ **DATE:** _____

WITNESSED BY: _____ **DATE**: _____