LIFESPAN THERAPY
Speech • Language • Cognition • Swallowing

Lifespan Therapy PLLC
4020 Hendersonville Rd. Suite E
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P: 828-222-4875
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RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I authorize Lifespan Therapy PLLC to ☐ release ☐ receive ☐ both release/receive the following information:

- ☐ Evaluation(s)
- ☐ Standardized testing
- ☐ Progress notes
- ☐ Discharge summary
- ☐ Medical, developmental, education, and/or social history

To/From: _____

Phone: _____ Fax: _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client / Authorized Representative Signature: _____

Date: _____