Speech-Language Therapy & Occupational Therapy
31815 Southfield Rd. Suite 15 Beverly Hills, MI 48025
248-885-8240 (office) 248-885-8270 (fax)
www.SmallTalkMI.com

Authorization to Release Protected Health Information

I desire that my child (or another child or person for whom I have legal responsibility), (in each case, the "patient") receive diagnosis, treatment, and/or care by SmallTalk Center for Speech and Language Development, PLLC, a Michigan professional limited liability company, including its therapists and other providers (collectively, the "Provider"), falling within the scope of a speech language, speech therapy and/or speech pathology practice, as such practice areas are commonly understood and/or within the scope of such practice areas as defined by the American Speech-Language-Hearing-Association. I understand that, in the course of such diagnosis, treatment, and/or care, and for the purpose of continuing and coordinating a plan of care, it will benefit the patient that the Provider discuss such diagnosis, treatment and/or care with one or more faculty members of the Patient's school, as identified below (the "School Faculty"). I understand that such information is or may be personal or individually identifiable health information and/or protected health information (the Protected Health Information") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA), 42 USC 1320d and 45CFR 160-164, as amended, and under the rules and regulations thereunder. I authorize and intend that the Provider release and disclose the Protected Health Information to the School Faculty, whether such Protected Health Information is now or later in existence. This authorization has no expiration date and shall expire only in the event that I revoke this authorization in writing and deliver it to the Provider, and then such revocation shall apply only with respect to disclosures made after such delivery of such revocation.

I give my permission to the staff of SmallTalk Center for Speech and Language Development, PLLC, to leave a message for me via email, voicemail or an answering machine or the U.S. mail regarding my healthcare, follow-up care and billing.

Print Name of Patient (if not Signer): _____

Print Name of Parent/Legal Guardian: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Name of Recipient (To whom we are releasing information): _____

Recipient Contact Information (phone/email address): _____