

Authorization for Release of Information

I give Kid's Communication Connection permission to use or share my health information with:

The information that will be used or shared includes (check all that apply):

- My medical records
- My treatment records (progress notes, daily records)
- My speech, language, or swallowing test results
- Other: _____

This information is being used or shared because:

This authorization will expire:

- On _____ (date)
- After the following event happens: _____

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time. I need to write to Karen Kleker at 4911 Warner Avenue Suite 215, Huntington Beach, CA 92649 to do this.
- Any information that was used or shared before I took back the authorization cannot be returned.
- The person or organization that gets my health information because of this authorization may have the right to share it with others without my permission.

Print Patient's Name

Date

Patient or Parent/Guardian Signature

Relationship to Patient