Consent of Disclosure of Health Information

*To show agreement, please initial each of the numbered sections below. Please also type the requested information in #1, and type your name, signature, and date at the bottom.*

1.       I hereby consent to the use and/or disclosure of individually identifiable health information about myself by mail, email, phone, or fax between New York Speech & Voice Lab PLLC and the following party:

 Name, email, and phone:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.       Any and all information from my health record that is relevant to evaluation and treatment may be sent and received by both New York Speech & Voice Lab PLLC and the party above.

3.       I understand that if I have an illness or injury that affects my voice, speech, language, swallowing, or upper airway, and if the above party is a relevant health care provider, this authorization may be required for New York Speech & Voice Lab PLLC to appropriately and sufficiently evaluate and treat me for the effects of this illness or injury.

4.       I understand that if the above party is not a health care provider, the shared information may no longer be protected by federal privacy regulations.

5.       I understand that I may revoke this authorization, in writing, at any time, and if I do, it will not have any effect on actions taken prior to the revocation, and that this authorization remains in force unless, and until, it is withdrawn in writing by me.

6.       I understand that I will receive a copy of this form after I sign it and may see a copy any time I ask.

 Legal name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of client: ELECTRONICALLY SIGNED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of client's parent or guardian if under 18: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[072920]