Atlantic Speech Therapy

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Patient Consent and Authorization Form

Patient Name: ______________________________Patient DOB: _____/_____/__________

Insurance Provider: _________________________Policy #:__________________________

Medicaid #: _________________________

1. I authorize Atlantic Speech Therapy, PC to render appropriate therapy services to the above named patient. I understand that care will be provided by an appropriately trained health care professional. I recognize and agree that I have the right to refuse treatment or terminate my services at any time by notifying Atlantic Speech Therapy office in writing. In addition, Atlantic Speech Therapy may terminate services by notifying me of termination. I hereby authorize Atlantic Speech Therapy to bill the North Carolina Division of Medical Assistance (Medicaid) or any other insurer identified by me and allow for the release of any information necessary to process claims for medical benefits.

2. I hereby authorize and request that copies of my prior medical record related to speech-language pathology evaluation or treatment services to be delivered to Atlantic Speech Therapy to establish or continue my health care treatment plan. This includes the complete assessment, most recent plan of treatment, progress summary, treatment notes and any other appropriately related documents of information.

3. I understand that for the purpose of continuing and coordinating my plan of treatment Atlantic Speech Therapy may be asked to release copies of my medical records, or such portions thereof as may be relevant to speech language pathology evaluation or treatment services, or reports or summaries thereof, to other health care providers, facilities (related to school or daycare staff, case managers, school systems, CDSA, etc.) and appropriately related professionals involved in my care. **My signature below indicates that I hereby authorize the release of my protected health information to the following people on an as-needed bases as determined by Atlantic Speech Therapy staff (choose all that apply):**

☐ **Release to other Entity or Individual:**

☐ Physician ☐ School Staff ☐Daycare Staff ☐CDSA Staff ☐Childcare Provider

☐ Related Professional Services Providers ☐Attendant Family Member ☐Custodial Foster Parent

☐ Insurance Group ☐Medicaid

This authorization will EXPIRE upon my discharge from patient services or upon my written request to deny future releases.

☐ **Any individuals or entities that I do <u>NOT</u> want my health information released to are listed specifically below:**

____

Patient/Authorized Representative SIGNATURE

I have read and fully understand the content and authorization release and hereby agree to and authorize the foregoing provisions. As used in this document, the terms “I”, “me” and “my” refer to and include, in addition to the undersigned, the patient name above and other

This consent to exchange information is fully understood and is made voluntary on my part.

____________________________	______________	_____________________
Parent/Guardian Signature	**Date**	**Relationship to Patient**