Peak Speech Therapy
19855 E Eastman Ave
Aurora, CO 80013
Phone: 720-477-0294
Fax: 720-324-4869

Authorization for Release of Health Information

Patient name: DOB:
Authorized Representative/Legal guardian: Phone:
Street address: City,State,Zip:

I hereby authorize Peak Speech Therapy to:

☐ Release (written/oral/electronic) information to: _____

☐ Receive (written/oral/electronic) information from: _____

Concerning care for the above patient from dates: **or ☐ any/all dates**

These records are to be released for the following reasons:

Patient request ☐ Continued care ☐ Other ☐

Information to be released:

I understand that this authorization allows the health care provider to discuss my individually identifiable health information described herein with the recipient of the information.

I understand that I may revoke this authorization at any time by notifying the health care provider. I understand that if I revoke this authorization it will not affect any actions that the health care provider took before it received my revocation letter.

Signature of patient or legally authorized representative: **Date:**

Printed name of patient/ legally authorized representative: **Date:**

Representative relationship to patient: