REQUEST TO DISCLOSE RECORDS

Kalamazoo Speech Associates
Center for Myofunctional and Speech-Language Therapy

CLIENT INFORMATION:

_____ _____
Client Name Date of Birth

PURPOSE OF THE DISCLOSURE:

☐ Continuation of care
☐ Other (must be specified)_____

RELEASING AND RECEIVING PARTIES

I, the undersigned, give my permission to Kalamazoo Speech Associates to obtain and review copies of all medical, hospital, dental, school, and other relevant records as well as to discuss relevant information with the people and organizations listed below. I also give my permission for Kalamazoo Speech Associates to disclose speech, language, and myofunctional evaluation and progress information with the people and organizations listed below:

Name _____
Address _____
Phone _____ Fax _____

Name _____
Address _____
Phone _____ Fax _____

Name _____
Address _____
Phone _____ Fax _____

Name _____
Address _____
Phone _____ Fax _____

This consent form is valid until revoked by me in writing.

_____ _____
Signature of client or personal representative Date

_____
Relationship to client (if signed by a personal representative)