HASA
CIRS Interpreting @ Gateway School
Hearing and Speech-Language Services

Permission to Obtain and Release Information

Client Name: _____ DOB: _____

Address _____

Phone _____ Email _____

Please provide the primary care physician's name, address and contact information below. This is required for all patients with Medical Assistance, but optional for patients with private insurance.

Physician Name _____

Physician Address _____

Phone Number_____ Fax _____

If you would like for the evaluation and progress notes to be sent to an additional person or organization, please list below.

Name _____

Address _____

I hereby authorize HASA to release pertinent clinical and/or educational information in written and/or oral form regarding evaluation, treatment, or ongoing progress for the above-named person, in the following disciplines:

☐Speech Language Pathology ☐Occupational Therapy ☐Audiology

☐I do not want my information or records released to anyone

_____ _____
Client (Parent or Guardian if client is a minor) Date

_____ _____
Witness Date

This consent will be in effect for one year from the date of signature. It may be revoked or revised in writing at anytime by the person giving permission on this form or by a minor child who reaches the age of majority during the effective year.

Revised: 1/2020