Speech & Occupational Therapy of North Texas *

1410 14th Street, Plano, Texas 75074
3880 Parkwood Blvd, Bldg 5, Suite 502, Frisco, Texas 75034
ph 972-424-0148 fx 972-422-5275

Patient Name: _____

Authorization to Leave a Voicemail

Please provide number(s) **ONLY IF** you approve us to leave **DETAILED** information related to the following, on your voicemail:

❑ Appointments ❑ Billing ❑ Test results, diagnosis, and procedures

Primary (_____) _____ **Secondary** (_____) _____

Authorization to Send a Text Message

Please provide a number **ONLY IF** you approve us to leave **DETAILED** text information related to the following:

❑ Appointments ❑ Billing ❑ Test results, diagnosis, and procedures

Primary (_____) _____ **Secondary** (_____) _____

Authorization to Send an Email Message

Please provide an email address below **ONLY IF** you approve us to send **DETAILED** information related to the following to your email:

❑ Appointments ❑ Billing ❑ Test results, diagnosis, and procedures ❑ Clinic Information

Email address: _____

Medical information will be released to, and/or requested from your child's primary doctor, in order to provide treatment:

Primary Care Physician: _____ Phone _____

Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent. I authorize this facility to speak to the following persons regarding (check which box applies):

❑ All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.

❑ Only the following types of information: _____

❑ Do not disclose any information on file other than to patient on record.

I give consent for information to be sent to or requested from the following: (specialists, school therapists, teachers, etc):

Parent : _____ Phone: _____

Specialist: _____ Type: _____ Phone: _____

Other : _____ Relationship: _____ Phone: _____

Other : _____ Relationship: _____ Phone: _____

By signing below I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPAA) and that I may request a copy of this Act at any time.

Name **(PRINTED)** _____ Relationship to Child_____

Signature_____Date_____

*DBA Speech and Language Services of North Texas, LLC