Speech Therapy Solutions Montana
2615 Colonial Drive Helena, MT 59601 (406) 422-4213

RELEASE OF HEALTH INFORMATION TO BE SHARED WITH STSM

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share the health information you indicate below. This does not keep the information from being shared with more people once it leaves our office. This authorization is valid for no longer than one year. If you decide later that you do not want us to share your information any more, you can request a REVOCATION FORM.

Client's Printed Name: _____ Date of Birth: _____

I give permission to Speech Therapy Solutions Montana to share and/or receive information with the following individuals / agencies:

Name: _____

Address: _____

City, State, Zip _____

Email: _____

Phone: ( ) Fax: ( ) _____

Name: _____

Address: _____

City, State, Zip _____

Email: _____

Phone: ( ) Fax: ( ) _____

- ☐ Information about my care and treatment with the above person or group
- ☐ Information from a certain time period (specify dates): From_____To _____
- ☐ All information relating to a certain event or injury and dates: (Must specify event and or dates)
  - Event _____
  - Date of Event _____
- ☐ Other (specify) _____

Client's Signature _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Relationship of Authorized Representative: _____ Date: _____

Witness signature: _____ Date: _____