CARY SPEECH SERVICES

Consent for Disclosure to Physicians
Right To Restrict And/Or Revoke Authorization

*It is the policy of **Cary Speech Services** to recommend that you allow us to inform your child's physician of our services. This policy is to help ensure coordination of care. Please indicate below if you are willing to grant such permission.*

I hereby consent to the use or disclosure of my child's diagnostic and treatment information to the individual physicians(s) or medical practice(s) listed below. I understand that the purpose of releasing this information is to coordinate treatment between the physician(s) and **Cary Speech Services.**

Physician Name: ____

Organization: ____

Street address: ____

City, State, Zip: ____

I understand that I have the ***right to revoke*** this consent in writing to the extent that the provider has taken action prior to the revocation.

I understand that this authorization is voluntary.

If you do not wish to have your child's physician notified of your child's treatment at **Cary Speech Services,** please indicate below.

_______ I do not want my child's physician notified about his/her evaluation and/or treatment at **Cary Speech Services.**

_______ I want to restrict disclosure to the following information:

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______________________________ ______________________
Signature of Parent or Guardian *Date*

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I want to revoke my authorization for disclosure of diagnostic and treatment information beginning on ______________________ (Date).

Signature of Parent or Guardian ______________________________