

GOEPFERT SPEECH ASSOCIATES, LLC
Diagnostic and Therapeutic Services for Children and Adults

431 East Chocolate Avenue
Hershey, PA 17033
Phone/Fax: (717) 533-1916

Release of Information

RE (Patient) : _____
D.O.B _____ PARENT/GUARDIAN _____
ADDRESS _____
EFFECTIVE DATE _____

We hereby authorize the PROVIDER:

(x) Release information to: _____ (x) Receive information from: _____

Name and Address: _____

Referring Physician: _____
Goepfert Speech Associates, LLC, 431 E Chocolate Ave Hershey, PA 17033 _____

The information may include:

- | | |
|---------------------------------|---|
| (X) Speech/Language Evaluations | (X) Developmental/Psychological Reports |
| (X) Educational Assessments | (X) Progress Reports |
| (X) Medical Reports | (X) Other: (describe) _____ |

Information received will be used to develop an appropriate service plan and will be subject to state laws protecting confidentiality. This information will not be released to any other person(s), agencies, or institutions. Any information generated by this agency will not be disseminated without signed authorization by the client and/or parent/guardian. Photostatic copies of this authorization shall be considered valid.

Please read the above form before signing.

Authorized signature-Client/Parent/Guardian

Date

Authorized signature-Client/Parent/Guardian

Date