Northwest Speech Therapy – Spotlight Social Skills

Regina Feinberg, M.A., CCC-SLP
8015 SE 28th Street, Suite 309
Mercer Island, Washington 98040
206.226.8813
Regina@SpotlightSocialSkills.com

AUTHORIZATION TO USE OR DISCLOSE INFORMATION

Client:_____________________________________ **Date:** _________________

I hereby give my permission to share protected information related to Speech/Language concerns or Social Skills.

The information is to be disclosed to or obtained from:

____
address ____
phone___________________________ fax and/or e-mail ______________________________

Information to be released is:

- ☐ Diagnostic or Assessment information
- ☐ Information related to coordination of services

The intent for release of this information is to coordinate care and maintain continuity of care with the practitioner, organization, or persons identified above.

This authorization is valid for no more than one year from the date of signature unless I have indicated a date sooner than that here_________________, and may be rescinded by my written notification at any time.

Limitations on release of information are: ☐ None

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Your Rights: You can end this authorization any time by writing to Regina K. Feinberg, MA-CCC at the above address. If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
If you have questions about anything on this form, contact Regina K. Feinberg, MA-CCC at (206) 226-8813.

Date _____________ Parent (or Legal Guardian) Signature _____________________________