Dietrich Speech & Language Services, LLC
growing roots and wings together

# FORM 3: Consent for Release of Information

**Patient Name:** _____ **Date of Birth:** _____

I, _____, authorize the release of protected health information
Parent/Guardian Name
pertaining to my child's care.

This information about my child's care includes, but is not limited to, speech-language:

- evaluation reports,
- treatment plans,
- progress notes,
- clinical documentation,
- discharge summaries,
- verbal communication.

This authorization releases relevant information about my child both:

1. **FROM:** Dietrich Speech & Language Services, LLC **TO:** the Entity listed below
2. **FROM:** the Entity listed below **TO:** Dietrich Speech & Language Services, LLC

| **FROM:/TO:**  | **TO:/FROM:**  |
|---|---|
| **Dietrich Speech & Language Services, LLC**<br>3579 Franklin Tower Drive<br>Mount Pleasant, South Carolina 29466<br>Phone: 843-810-9198<br>Toll-Free Fax: 855-279-3149<br>E-mail: records@secure.dietrichspeech.com | _____<br>**Practice/Provider Name**<br>_____<br>**Street Address or Post Office Box Number**<br>_____<br>**City** **State** **Zip Code**<br>_____<br>**Phone Number** **Fax Number**<br>_____<br>**E-mail Address** |

This protected health information and patient record(s) are to be used for diagnostic and treatment planning purposes only. It is my understanding that this information will not be shared with any other entity without my prior knowledge. I further acknowledge that the use of any shared health information is to ensure the best quality of care possible for my child. Dietrich Speech & Language Services, LLC thanks you for your prompt attention in this matter.

**Parent/Guardian Printed Name:** _____ **Date:** _____

**Parent/Guardian Signature:** _____