Lannon Twomey
MS CCC-SLP
speech-language pathologist

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Authorization of Release of Information Form

Completion of this form will serve as written permission for Lannon Twomey, MS, CCC-SLP, speech-language pathologist to communicate with the individuals you have listed below for the purposes you identify. This authorization will be considered valid throughout the course of treatment unless otherwise requested by the patient and/or guardians.

Patient Name: ____

I authorize release of information by Lannon Twomey, MS, CCC-SLP, speech-language pathologist, to (list names and contact information of individuals): ______________________
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For the purposes of (check all that apply):

______ Coordinating services, techniques, treatment strategies among other professionals (school personnel, pediatricians, audiologists, etc.)
______ Updating progress towards goals
______ Providing continuity of services (relocation, change of service provider, etc.)
______ Other: ____

Shared information may include:

______ *No restrictions, all information relevant/pertinent to coordinating patient treatment*
-OR-
______ Session notes only
______ Evaluations only
______ Informal progress updates only
______ Other: ____

Communication to/from these individuals may occur in a variety of ways (in person, phone conversations, email, fax transmittals, etc.) and may include information from the patient's medical record, for example, speech-language evaluation results or effective speech-language therapy strategies and techniques. Please know you have the right to restrict ***how*** information about you or your child is shared. Kindly indicate any restrictions you wish to request regarding how information about you or your child is shared with the above named individuals.

______ I do not have any restrictions for how information is shared.
______ I wish to apply the following restrictions (i.e. phone calls only, no emails, ect.): ______
____

Signed: ____
Printed Name/Relationship to Patient: _________________________________