

Elizabeth I. Smith, M.A., CCC
Speech-Language Pathologist

Patient Authorization for Use & Disclosure of Protected Health Information

By signing, I authorize Elizabeth I. Smith to use and/or disclose certain protected health information (PHI) about me to: ___Insurance Co., ___Attorneys, ___Family Member, ___Spouse, ___Dentist, ___Mental Health Professionals, ___Doctors, ___Teachers, ___Other Speech-Language Pathologists, ___Audiologists, ___Other (Please Specify)_____

This authorization permits Elizabeth I. Smith to use and/or disclose the following individually identifiable information about me (specifically describe the information to be used or disclosed, such as date of services, type of services, level of detail to be released, origin of information, etc.; may write in "SLP discretion" if you so desire):_____

The information will be used or disclosed for the following purpose: ___treatment, ___consultation, ___evaluation, ___counseling, ___other (please specify)_____.
(If disclosure is requested by the patient, purpose may be listed as "at the discretion of the SLP".)

This authorization will expire on, or when _____ (furnish date or defined event)
Automatically valid for 6 years unless otherwise specified or dated.

I do not have to sign this authorization in order to receive treatment from Elizabeth I. Smith. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Elizabeth I. Smith, M.A., CCC
6672 Gunpark Drive, E., Suite 101A
Boulder, CO 80301

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Patient's Name Date

Print Name or Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

Authorization must be received for reasons other than routine treatment, payment, or health care operations. Elizabeth I. Smith will not furnish PHI without a signed authorization.