Dallas Reading and
Language Services
HIPAA Release of Health Information

Your family and child's doctor will receive all evaluations and monthly summary reports. Complete this form if you would like us to send information to another doctor, therapist, counselor, school or teacher.

Information to be released:

___ Initial Evaluation and Re-Evaluations ___ Monthly Summary Reports
___ Discharge Summary/Evaluation ___ Therapy SOAP notes (only released on request)

I grant permission to release protected health information for my child _____________________________ to the following people or agencies:

Family
List Family members that we can share this information with: ___________________________________

____________________________________________________________________________________

List Additional Doctors/health care professionals that you would like to receive these reports
Name:_________________________ Phone _______________ Fax ______________________
Name:_________________________ Phone _______________ Fax ______________________
Name:_________________________ Phone _______________ Fax ______________________

Schools:
Would you like us to share this information with your child's schools and teachers: If yes fill in the information
Name of School: _______________________ Phone _______________ Fax ______________________
Contact person at the school you would like to receive it: _______________________________________
Names of Teachers you would like to receive it: ______________________________________________

_________________________ Phone _______________ Fax ______________________

Monthly Summary E-mails  E-mail Address: __________________________________________

___ I give permission for Dallas Reading and Language Services to send Monthly Summary Reports to the above listed agency/person via e-mail. All e-mails include a Confidentiality Statement with limited terms of use for the Protected Health Information of the client.

Parent or Guardian Printed Name and Signature

____________________________________________  ______________________________________

Signature of Parent or Guardian  Date