Cincinnati Center for Improved Communication, Inc.
Services in Speech, Language, and Language-Based Learning Disorders

AUTHORIZATION FOR RELEASE OF INFORMATION

This Authorization must be completed *before signing.*

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

SECTION A – Complete for all authorizations

I hereby authorize the use of disclosure of ***my own*** ***my child's*** (strike through inapplicable description), individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Patient's Full Name:_____

Patient ID Number:_____

Organization providing the information: **Cincinnati Center for Improved Communication, Inc.**
4440 Carver Woods Drive, Suite 100, Cincinnati, Ohio 45242

Persons/organizations receiving the information:

Name: _____

Address: _____

_____

_____

Valid term of authorization: _____ until patient no longer receives services.
(effective/current date)

Specific description of information (including date[s]):

_____

_____

_____

_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

SECTION B – Complete only if Cincinnati Center for Improved Communication, Inc. has requested the authorization for its own purposes or for use or disclosure by another plan or provider.

1. **To be completed by Cincinnati Center for Improved Communication, Inc.:**

    a. What is the purpose of the use of disclosure? _____

_____

_____

    b. Will Cincinnati Center for Improved Communication, Inc. receive direct or indirect financial or in-kind compensation in exchange for using or disclosing the information described above:

Yes _____ No _____

2. **The patient or the patient's representative must read and initial the following statements:**

    a. I understand that Cincinnati Center for Improved Communication, Inc. will not condition treatment on my providing this Authorization, except in the case of research-related treatment. **Initials: _____**

    b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

Initials: _____

SECTION C – Complete for all authorizations.

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire when I am no longer a patient of Cincinnati Center for Improved Communication, Inc. **Initials: _____**
2. I understand that I may revoke this authorization at any time by notifying Cincinnati Center for Improved Communication, Inc. in writing, except to the extent that action has been taken in reliance on the authorization. **Initials: _____**

Signature of patient or patient's representative:

_____

Date: _____

Printed name of patient's representative:

_____

Basis of representative's authority to act for patient (example, parent/legal guardian):

_____