Authorization for Release and Request of Protected or Privileged Health Information

Child/Client Name:
Date of Birth:
Address:
Telephone:

I, _____ certify that I am the parent or legal guardian of the child named above. I hereby authorize Melissa Ghiringhelli, MS, CCC-SLP/ Harbor Education Strategies to release and receive protected information regarding my child's medical history, developmental needs educational goals, etc. with the following persons at the locations/facilities listed below:

Name: _____

Phone #:_____

Email:_____

Facility Name: _____

Address: _____

I understand that this authorization will expire upon discontinuation of therapy with Harbor Education Strategies/Melissa Ghiringhelli, MS, CCC-SLP, unless otherwise specified here _____. I understand that I may refuse to sign or may revoke (at any time) the Authorization for any reason, and that such refusal or revocation will not effect the commencement, continuation, or quality of Melissa Ghiringhelli, MS, CCC-SLP/ Harbor Education Strategies's treatment of my child.

I hereby release Melissa Ghiringhelli, MS, CCC-SLP/ Harbor Education Strategies from all legal responsibility or liability that may arise from the release of this information or redisclosure by the recipients. I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my child's condition to those persons or agencies listed above.

Signature of Legal Representative: _____ Date:_____

Print Name: _____ Relationship to Client: _____

Harbor Education Strategies Melissa Ghiringhelli, MS CCC-SLP
Address: 99 Derby Street, 2nd Floor, Suite 217, Hingham, MA 02043
Phone: 978-621-7230 Email: melissa@Harboreducationstrategies.com