LITTLE EXPRESSIONS
SPEECH-LANGUAGE THERAPY

Consent to Release/Obtain Information/Payment/ Treat & Acknowledgment That You Have Received Our HIPAA Privacy Notice

I have been informed of the use and release of information collected through services received in regards to:

_____ . I request that copies of information in regards to my child be released
(patient's full name) to/from:

1. _____, 2. _____
(Child's Doctor) (Payer/Insurance)

3. _____, 4. _____
(Other Doctors) (School-if Appropriate/Daycare)

5._____, 6. _____
(Babynet- if applicable) (Other)

(Please read the following and then **Initial Below***)*

_____I request that payment of authorized Medicaid and third party payer's benefit be made to *Therapy Consortium Inc. & Little Expressions Speech Therapy LLC* on my behalf for services furnished to me.

_____ I authorize *Therapy Consortium Inc. & Little Expressions Speech Therapy LLC* to release any medical information about me that may be needed to determine these benefits payable for related services.

_____I understand that I will **NOT** be billed for any Medicaid services furnished to me which were billed to Medicaid during the time I had Medicaid coverage for those services.

_____I understand that *Therapy Consortium Inc. & Little Expressions Speech Therapy LLC* are required by law to give me a copy of the privacy notice. I understand how my health information may be used and shared.

_____I understand that *Therapy Consortium Inc. & Little Expressions Speech Therapy LLC* are required by law to keep my health information safe. This information may include:

- Notes from your doctor, teacher, or other health care provider
- Your medical history & any treatment notes
- Test Results
- Insurance information

By signing this page you consent to have your child treated by Little Expressions Speech Therapy LLC for Speech-language services and that you have been given a copy of our privacy notice.

Parent/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____