Milwaukee Myo
Mequon Speech and Learning Connection

RELEASE/EXCHANGE OF INFORMATION

Federal Privacy Laws require our practice to obtain patient/parent/legal guardian permission to release, use and/or share protected patient medical information. By completing this form, you are providing our practice with permission to share information with an entity or source which did not originate in this agency. We appreciate your time and cooperation.

PATIENT NAME: _____

PATIENT BIRTHDATE: _____

PATIENT ADDRESS: _____
Street *City/State* *Zip*

PATIENT PHONE: (____) _____/H_____/W_____/C

INFORMATION RELEASED/EXCHANGED FROM:
Milwaukee Myo/Mequon Speech and Learning Connection (MM/MSLC)
1025 W. Glen Oaks Lane, Suite 107
Mequon, WI 53092

INFORMATION RELEASED/EXCHANGED TO:

NAME: _____

COMPANY OR PRACTICE NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: (____) _____

Please indicate any restrictions on information that we may share/release (including but not limited to drug and/or alcohol treatment or testing, HIV information and Mental Health Information).

AUTHORIZATION FOR SPECIAL RELEASE OF MEDICAL INFORMATION
I voluntarily give my authorization/permission for MSLC to release, exchange, use and/or share the medical information from my records, including any information or opinions regarding my condition or treatment. I hereby release MSLC from all legal responsibility that may arise from this authorization. I understand that once this information is released, used and/or shared, the entity that received it may share it again. If this happens, the information may no longer be protected under applicable privacy laws. I understand what type of information is going to be released, used and/or shared and how this is going to be done. If I wish to withdraw my permission, I agree to put my request in writing and to send it to MSLC at the above address. My letter will state who may no longer receive my patient medical information. I understand that if I send a letter withdrawing my permission, that letter cannot bring back any information that was already released, used and/or shared. I also understand that it will take time for MSLC to receive and process my request. I have read this document and fully understand its contents and significance.

Patient Signature: _____

Name: _____ Date: _____

Parent/Guardian's Signature: _____

Name: _____ Date: _____