RiteCare SPEECH AND LANGUAGE THERAPY OF WASHINGTON
Childhood Speech and Language Programs

Authorization for Release of Healthcare and/or Education Information

I hereby authorize the exchange of information between RiteCare of Washington, and:

_____
(individual/agency)

_____
(address)

_____
(phone)

Regarding: _____
(name)

The exchanged information may include:

Speech and Language _____
Educational _____
Psychological _____
Medical _____

Purpose for which disclosure is being made: Speech/Language Evaluation and Treatment

My Rights: I understand the following:

1. My express consent is required to release any healthcare information related to testing diagnosis or treatment.
2. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment, or ineligibility for benefits.
3. I may revoke this authorization at any time in writing, but the revocation will not apply to information already disclosed.
4. I am entitled to a copy of this document and a notice of privacy practices from the above provider. Please note there may be a charge for the release of these records pursuant of 45 CPR 164.524 (c) (4) (HIPAA).
5. This authorization shall expire **one year** from the date below or upon written request. A copy of this authorization is as valid as the original.

Please send information to:

RiteCare of Washington
1207 North 152nd Street, Suite A
Shoreline WA 98133

RiteCare of Washington
157 S. Howard Street, Suite 310
Spokane, WA 99201

Signature: _____ Date: _____

Relationship to patient: _____