COVENANT
COUNSELING & CONSULTING
EMPOWERING PEOPLE. BUILDING RELATIONSHIPS. CHANGING LIVES.

Consent to Release Private Information

I hereby authorize **Covenant Counseling and Consulting, LLC** to use or disclose health information about my child. The use or disclosure shall be limited to the information, persons, purposes, and timeframe described below.

Information to be used or disclosed

I authorize the use or disclosure of the following protected health information:

☐ Evaluations

☐ Therapy Visits

☐ Communication Documentation

☐ Patient Care Summaries (including Discharge Summaries)

☐ Other: _____

Speech Language Pathology Records

I hereby authorize **Covenant Counseling and Consulting, LLC** to release the above information to and obtain information from:

_____			
Child's School	Phone Number	Fax Number	Email Address
_____			
Caregiver Name	Phone Number	Fax Number	Email Address
_____			
Physician	Phone Number	Fax Number	Email Address
_____			
Other	Phone Number	Fax Number	Email Address

I understand that I may change this authorization at any time.

_____ _____

Parent/Guardian Signature Date