firstrowe
speech & feeding therapy center

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Brooklyn, NY 11235
646.905.8100
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Authorization for Release of Information

I give FirstRowe Speech Pathology, P.C. permission to use or share health information for with:

____

The information that will be used or shared includes (check all that apply):

- ☐ Medical records
- ☐ Evaluation
- ☐ Treatment records (progress notes, daily records)
- ☐ Speech, language, or swallowing test results
- ☐ Other: ______________________________

This information is being used or shared because:

____

This authorization will expire:

- On ______________________ (date)
- After the following event happens: ______________________

I understand that:

- I do not have to sign this authorization. I will still be able to get treatment here even if I do not sign it.
- I am allowed to see or copy the health information that will be used or shared.
- I can take back this authorization at any time. I need to write to FirstRowe Speech Pathology, P.C. at 2844 Ocean Pkwy, Brooklyn, NY 11235 to do this.
- Any information that was used or shared before I took back the authorization cannot be returned.

______________________________ ______________________
Print Patient's Name Date

______________________________ ______________________
Patient or Parent/Guardian Signature Relationship to Patient