Watson Speech and Language Services

Authorization for Use or Disclosure of Protected Health Information

Patient: _____ Birth Date: _____

I hereby authorize Watson Speech and Language Services to use or disclose the above patient's protected health information as described below:

1. I authorize Jennifer Watson to release information to the following entities:
   - ❑ Family Physician: Dr. _____ at_____
     _____
   - ❑ School Speech Therapist: _____
     at school named:_____
   - ❑ Other: _____

2. I give Jennifer Watson permission to communicate with me via:
   - ❑ email
   - ❑ voicemail
   - ❑ text

Please note: if you authorize the use of email, we cannot guarantee that we can keep your health information protected because this is not a secured method of communication.

I am aware that Watson Speech and Language Services has a notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice prior to signing this consent and that I may request a copy of the Notice if I so desire.

Signed: _____
Print your name: _____
Today's Date: _____

This release is open-ended until I sign a different form indicating other choices, or after 7 years from the date above.

4 Dundee Circle, Harwich, MA 02645
Office # 508-237-6643
watsonjslp@gmail.com
www.watsonspeechandlanguage.net