HEALTH INFORMATION RELEASE FORM

In order to assist you in receiving your health information, please complete this form.

I authorize **Diana G. Masker, M.A., CCC/SLP,** to have access to any and all of my child's health records, including HIV status. **Diana G. Masker M.A., CCC/SLP** is permitted to share health information with those listed below, including test results and information obtained during office visits.

Please initial beside persons authorized to receive medical information: Please include name and phone.

___ Child's physician's _____

___ _____

___ The person who referred me _____

___ My insurance company _____

___ Early Steps _____

___ School Personnel _____

___ Other _____

___ Other _____

You may notify me with test results, appointment reminders, and other information regarding my health information as follows:

___ Message on answering machine Phone # _____

___ Message on work voicemail Phone # _____

___ Message on cell phone Phone # _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____

Patient-Print Name Witness-Print Name

_____ _____

Patient/Guardian Signature Witness Signature

Date _____