

Authorization for Release of Information

I give Jocelyn M. Wood 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 Jocelyn M. Wood, 1155 Ocean Avenue, #3A, Brooklyn, NY 11230 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