speech matters

PATIENT CONSENT FOR RELEASE OF INFORMATION

I, _____(*print name*), in accordance with federal regulations governing privacy of medical information, agree to permit Linda Bejoian, M.S., CCC/SLP, or a member of her staff, to release any protected health information in my medical records for purposes of treatment, payment, or healthcare operations. These purposes include, but are not limited to providing information to:

1. Other health care professionals, and others for continuity of care and ford referral;
2. Your insurance company for payment;
3. Utilization review, peer review and quality assurance organizations.

In addition, I authorize any of the previously designated, parties to release any medical information they have about me to Linda Bejoian, or a member of her staff.

AGREE AND ACCEPTED:

_____

Patient Signature

_____

Print Name

_____

Date

210 East 86th St STE 202 New York, NY 10028
Phone: 212.861. 7800 Fax: 212.861.7801 linda.bejoian@gmail.com