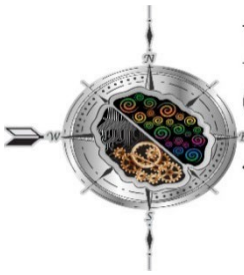

# Pathways To Communicate, LLC

Amanda K. Myers M.S., CCC-SLP

## Medical Information Release

(Authorization for use or disclosure of Protected Health Information)

I authorize Pathways To Communicate, LLC. to gather, use, and disclose my medical information for the purposes of treatment, payment, and healthcare operations:

*Treatment* includes activities performed by a healthcare provider, nurse, office staff, and other types of healthcare professionals providing care to the client, coordinating or managing the client's care with third parties and consultations with and between other healthcare providers. This consent includes treatment provided by any therapist who covers Pathways To Communicate, LLC by telephone as the on-call therapist.

*Payment* includes activities determining your eligibility for health plan coverage, billing, and receiving payment from your health benefit claims, and utilization management activities which may include review of healthcare services for medical necessity, justification of charges, pre-certification and pre-authorizations. I understand that I will be personally responsible for any amount denied or any remaining amount owed for services partially or not covered by my third party payer.

*Healthcare operations* include necessary administrative and business functions of our office.

I further authorize Pathways To Communicate, LLC to use and disclose health and medical information related to therapy, evaluation, assessment, progress notes, and plan of care for the following listed purpose(s):

Collaboration of services with: Speech and Language Pathologists, Physical Therapists, Occupational Therapists, Psychologists, Physicians, Teachers, School Administrators, and other authorized business office personnel.

## Consent to Evaluate and Treat

I authorize Pathways To Communicate, LLC to screen, evaluate and provide the necessary speech-language therapy.

Treatment is based upon the findings of the evaluation and the recommendations of the responsible speech-language pathologist.

I understand I have the right to revoke the consent provided and will do so in writing, except to the extent that Pathways To Communicate, LLC has already evaluated, treated, used or disclosed the information in reliance on this consent.

_____ _____

Please print name of patient DOB Date

_____ _____

Signature of patient/responsible person (if patient is a minor) Relationship to patient

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Fax: 541-264-5573
Email: pathwaystocommunicate@gmail.com