Associated Speech & Language Services, P.A.
104 E. Pennsylvania Ave.
Suite 302
Towson, MD 21286
Tel: 410-825-9445
Fax: 410-296-5710

Pat Ourand, MS, CCC-SLP
Lauren M. Gallagher, MS, CCC-SLP
Christine Dufrane, MS, CCC-SLP
Richard Gubisch, Office Manager

Authorization for Treatment and Release of Speech/Language Records

Patient: ______________________________

Treatment Authorization:

The undersigned patient or patient's parent, legal guardian, or responsible party, hereby consents to any and all evaluation and treatment procedures recommended by the speech/language pathologists of Associated Speech and Language Services – Patricia R. Ourand, MS, CCC-SLP, P.A.

Release of Speech/Language Records:

The signing party hereby authorizes Associated Speech and Language Services – Patricia R. Ourand, MS, CCC-SLP, P.A. to furnish information from the patient's records to any insurer of patient, and to any agencies or individuals providing medical, social, or educational services to the patient. The signing party hereby authorizes Associated Speech and Language Services – Patricia R. Ourand, MS, CCC-SLP, P.A. to furnish information that would be helpful to the following:

Patient/Parent: ____

Address: ____

City, State, Zip: ____

Phone: ______________________

Insurance Co.: ____

Address: ____

City, State, Zip: ____

Phone: ______________________

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Doctor/dentist/orthodontist: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ____________________

Other (e.g., school): ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ____________________

Consent is also given for the release of information to Associated Speech and Language Services – Patricia R. Ourand, MS, CCC-SLP, P.A. by any insurer of the patient and/or all agencies or individuals from whom the undersigned has received medical, educational, or social services.

This authorization covers information presently in the patient's record, as well as future information for a period of one year from the date of this authorization. The undersigned certifies the he/she has read the foregoing and understands it and that any questions have been answered. The undersigned further certifies the he/she is the patient or patient's parent, legal guardian, or responsible party and is authorized to execute the above.

Signed: ______________________________ Date: ______________

Relationship to Patient: ____________________

Witness: ______________________________ Date: ______________