OroFacialTx, PLLC
Sue Merino M.A., CCC-SLP
Orofacial Myofunctional & Speech Therapy
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Authrorization for Release of Information

This authorization, or photocopy hereof, will authorize OroFacialTx, PLLC to obtain and furnish pertinent information it may have regarding the condition of _____ while under her observation and treatment. This information may be obtained from and/or released to:

Dentist_____ Address_____ Phone_____

Orthodontist_____ Address_____ Phone_____

Other_____ Address_____ Phone_____

Signature_____
(Signature of parent or guardian if patient is under 21 years of age)

I have received a copy of the Notice of Privacy Practices in compliance with HIPAAA (Health Insurance Portability and Accountability Act) guidelines.

Signature_____ Date_____

Relationship to Patient_____

Patient Name_____

Patient's Date of Birth_____