

SZ THERAPIES RELEASE OF INFORMATION

SCOTT ZISCHKE MA, CCC-SLP
SZ THERAPIES
9233 PARK MEADOWS DRIVE #225
LONE TREE, CO 81024
P: 303-625-4092
F: 303-625-4093

RELEASING PARTIES

COMPANY: SZ Therapies
ADDRESS: 9233 Park Meadows Drive
Suite #225
Lone Tree, CO 81024
PHONE: 303-625-4092
FAX: 303-625-4093

NAME: SCOTT ZISCHKE MA, CCC-SLP
RELATIONSHIP: Speech Language Pathologist
at private office
PURPOSE OF RELEASE: _____

COMPANY: _____
ADDRESS: _____

PHONE: _____
FAX: _____

NAME: _____
RELATIONSHIP: _____

PURPOSE OF RELEASE: _____

PURPOSES - continuing care / legal / insurance processing / at patient request

INFORMATION TO BE RELEASED

- | Item (Dates to/from) | Item (Dates to/from) |
|--|--|
| <input type="checkbox"/> Tx Progress Reports () | <input type="checkbox"/> Home Health Records () |
| <input type="checkbox"/> Evaluation Reports () | <input type="checkbox"/> Hospital Records () |
| <input type="checkbox"/> Lab Results () | <input type="checkbox"/> Education Records () |
| <input type="checkbox"/> Other: _____ () | |

AUTHORIZED SIGNATURES

My signature below authorizes the above-marked information to be released to the above-identified parties via secure email, fax, or post mail. I understand I may revoke this authorization in writing at any time. It will not however nullify any actions taken by either party before my revocation.

- Patient is a minor Signature is for revocation

Date Signature of patient or authorized representative Relationship to patient

This authorization expires 90-days from date of signature unless otherwise noted here:

Copying medical records may incur a fee at some licensed facilities. The patient must pay this fee in advance.