Speech Leaps LLC
1858 Smallwood Road
Ridgeway, SC 29130
803-553-0813 Fax: 803-787-0507
speechleapssc@gmail.com

Release of Information/Consent to Bill

Authorization to release

I consent to the release of information regarding services rendered by Speech Leaps LLC to my insurance company or any governmental payer of the medical expenses as listed below, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also consent to the release of all medical information to my family physician and other treating physicians/laboratories, as listed by me below, as well as to any physicians/therapists to whom Speech Leaps LLC may refer me for purposes of further treatment/diagnosis. I consent to the use and/or release of medical information about me for purposes of health care operations, as it relates to Speech Leaps LLC's internal centers and general administrative activities. In addition, if the client is a minor child, I, as parent or guardian, consent to the release of medical information to the child's other parent, or the person (s) that I have listed as being responsible for the medical bill. I understand that this consent to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes, or for purposes of subsequent treatment. Further, this consent is valid for the disclosure of medical information contained in hard copy or in electronic form, including, but not limited to, electronic mail ("email") and facsimile.

Authorization to Obtain

I authorize Speech Leaps LLC/Susan Combs MCD, CCC-SLP to obtain information as it relates to this client's therapy and billing from the following medical and professional organizations.

Name of Organization _____ Phone: _____

Address: _____

Name of Organization _____ Phone: _____

Address: _____

Name of Organization _____ Phone: _____

Address: _____

Rights to Revoke

This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that Speech Leaps LLC has taken action in reliance upon my consent.

Client Name _____DOB_____
Please Print

Client/Parent/Guardian Signature_____Date_____

Medical Information Authorization