

TEGA CAY SPEAKS

Consent to Release / Obtain Information / Payment / Treat

I have been informed of the use and release of information collected through services received in regards to: _____ . I request that copies of information in regards to my child be released to/from:

1. Tega Cay Speaks
2. _____
3. _____
4. _____
5. _____

I request that payment of authorized Medicaid and third party payer's benefit be made to Tega Cay Speaks on my behalf for services furnished to me. I authorize them to release any medical information about me that may be needed to determine these benefits payable for related services.

I consent to have my child treated by Tega Cay Speaks for Speech/Physical/Occupational Therapy Services.

Patient/Parent or Guardian Signature

Date

Witness

Date