

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: (patient's full name) ______. I request that copies of information in regards to the patient be released to and from:

 Columbia Speaks

 2.

 3.

 4.

 5.

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

I consent to have my child treated by Columbia Speaks for speech therapy services.

Patient/Parent or Guardian Signature

Date

Witness

Date