Speech & Hearing ASSOCIATES
SHA Since 1969
AUDIOLOGY • HEARING AIDS • SPEECH THERAPY
- Exceptional care for the entire family -

Authorization for Release of Information to SHA

RE: _____ _____
PATIENT NAME DATE OF BIRTH

I AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION:

_____ Medical Records
_____ Neurological Report
_____ Neurodevelopmental Evaluation
_____ Child Study Team Evaluations
_____ Speech Therapy Progress Notes
_____ Other _____

_____ ENT Report
_____ Audiological/CAP Evaluation
_____ Learning Specialist Report
_____ Speech Language Evaluation
_____ Treatment Plan

RECORDS FROM:

_____
(Person, Organization, or Institution)

_____
(Street Address)

_____
(City) (State) (Zip)

PLEASE PROVIDE THE RECORDS REQUESTED ABOVE TO:

SPEECH AND HEARING ASSOCIATES, LLC
ATTENTION: CHARLOTTE
121 SOUTH EUCLID AVENUE
WESTFIELD, NJ 07090
or
FAX TO: 908-232-3583 OR EMAIL TO: CBONANNE@SHA1969.COM

_____ _____
PATIENT OR PARENT/GUARDIAN SIGNATURE DATE

_____
PRINTED NAME

rmfk/12