READ ONLY

Amplify Speech Therapy is required by law to keep your health information safe. The Health Insurance Portability and Accountability Act, or HIPAA, requires that Amplify Speech Therapy, LLC provide you with a copy of this privacy notice. You will be asked to acknowledge that you have received and read this notice on the Consent Form.

Amplify Speech Therapy follows HIPAA guidelines and takes every measure to secure your information by using only secure platforms that include multifactor authentication and encryption of data.

How your health information may be used or shared

Amplify Speech Therapy will only share your medical information, which may include treatment notes, evaluation/test results, information provided by your doctors, and insurance information for the following reasons:

- To conduct and communicate treatment with other providers (such as your referring doctor)
- To submit treatment updates, progress notes and request additional visits from your insurance company or other payer source
- To run internal studies to determine best outcomes in how service is delivered and improve the company's practices
- When bound by law to report abuse or neglect
- As required by law when mandated to report to federal, state or local governments
- In reporting to public health agencies as required by law to help in preventing disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration
- Regulatory oversight, such as when health agencies require audits, licensure or inspections
- When there is reason to believe there is threat to health and safety of others
- If seeking therapy in connection with Worker's Compensation from your employer

Additional information regarding patient rights under HIPAA can be found at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

The next page is optional. If you would like to request release of medical records to Amplify Speech Therapy, please fill out and return the following form.

AMPLIFY
SPEECH THERAPY • FIND YOUR VOICE

MEDICAL RECORDS RELEASE FORM
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, of _____, hereby authorize Amplify
(name) (City, State)

Speech Therapy, LLC to use, disclose and/or discuss the following protected health information listed below from my medical records. I understand the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and if so, may not be subject to federal or state law protecting confidentiality.

Persons or entities with whom Amplify Speech Therapy, LLC may disclose/discuss your Protected Health information: (i.e. Doctors, Therapists)

Name/Title	Address	Contact Information (phone, fax)

Amplify Speech Therapy, LLC is authorized to disclose/discuss the following information, including but not limited to: medical records; treatment records (progress notes, daily session notes); speech, language and or swallowing test results; and rehabilitation progress as it relates to therapy/treatment and evaluations at Amplify Speech Therapy, LLC.

This information is being used or shared for medical, insurance, and/or legal purposes.

I understand that I may revoke this authorization at any time by requesting such of Amplify Speech Therapy, LLC in writing, unless action has already been taken in reliance up on it, or during a contestability period under applicable law.

_____

Client Signature Date

_____

Client Printed Name