

# Creative Speech Solutions, LLC

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Director

## REQUEST TO RELEASE AND/OR OBTAIN PATIENT RECORDS/INFORMATION

NAME OF PATIENT: \_\_\_\_\_

I authorize Creative Speech Solutions, LLC to (release / obtain) information, records, and reports (to / from)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date