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:

1. **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