

**Alaska Speech and Hearing Clinic**  
2401 East 42<sup>nd</sup> Avenue, Ste #101  
Anchorage, AK 99508-5228  
(907) 562-4550  
(907) 562-4554 Fax

**Consent for Evaluation**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I give permission for my child to be evaluated by Alaska Speech and Hearing Clinic. The information obtained during the evaluation is confidential and can not be shared with other people or agencies without written consent. All information will be shared with the family in writing and verbally. The family can request information to be shared with other agencies by signing a release of information.

\_\_\_\_\_  
Parent/Guardian Signature Date

**Release of Information**

I grant permission for Alaska Speech and Hearing Clinic to release and receive: medical records, evaluations, progress notes and other information as listed: \_\_\_\_\_ with the following agencies:

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

This release is effective until revoked or the child is no longer receiving services.

\_\_\_\_\_  
Parent/Guardian Signature Date



Alaska Speech and Hearing Clinic has agreed to submit bills directly to the insurance provider. The family will be billed for all deductibles and co-payments. It is the responsibility of the family to pay all outstanding bills not covered by insurance based on policy coverage of speech and language therapy.

I authorize ASHC to bill my insurance provider directly and agree to be responsible for all amounts not covered by insurance company (exclusion: Tricare/medicaid). I also agree to allow ASHC to release any medical records that are required by the insurance carrier for payment of service.

\_\_\_\_\_  
Child's Name Date of Birth

\_\_\_\_\_  
Parent/Guardian Signature Date

