



Scottish Rite Childhood Language Center
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AUTHORIZATION FOR INFORMATION RELEASE

I give permission to the following agencies:

To release my child's Protected Health Information to:

**The Scottish Rite Childhood Language Center
4202 Hermitage Road
Richmond, Virginia 23227-3755**

Name of Patient: _____

Date of Birth: _____

I understand this request authorizes the disclosure of my child's protected health information, and that this information may be used in the care and treatment of my child by the Scottish Rite Childhood Language Center.

This information may also be used if needed, in the submission of claims to my insurance carrier, once I have given expressed written consent.

Signature of Parent or Guardian Date

Witnessed by Date