Untethered
AIRWAY HEALTH & TONGUE-TIE CENTER

2524 E. Webster Place #201a – Milwaukee – WI – 53211 – 414.935.8460 (P) – hello@untetheredttc.com

Authorization to Release & Discuss Information - The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. ***Please provide all names of providers you want us to be able to speak with.*** You may opt out by checking the "Do Not Release Information" box below.

HEALTHCARE PROVIDERS

Patient Name: _____ **D.O.B.** _____

General Physician – Name/Location_____

Pediatrician – Name/Location _____

Lactation Specialist/IBCLC – Name/Location _____

Myofunctional Therapist – Name/Location_____

Dentist – Name/Location _____

Orthodontist – Name/Location _____

Chiropractor – Name/Location _____

Speech Pathologist – Name/Location _____

Craniosacral Therapist – Name/Location _____

Physical Therapist – Name/Location _____

☐ Do Not Release Information to Anyone

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient or Guardian Signature: _____ Date: _____