AUSTIN SPEECH LABS
stroke recovery one word at a time

Medical Release Form

Name: _____ Date: _____
Address: _____ DOB: _____
_____ Date of Stroke: _____
Phone: _____
Neuroimaging Location: _____

I, _____, authorize Austin Speech Labs to access my physician reports and neuroimaging scans and reports related to my stroke in the form of a hardcopy and digital copy.

This release is effective from _____ until _____.

Signature of Patient: _____ Date: _____
Signature of Guardian: _____ Date: _____

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