SuperiorView **Swallowing Diagnostics**
1050 Sand Run Road Akron, Ohio 44313
email Beth@superiorviewfees.com phone (330)388-7050

Authorization to Evaluate / Release of Information

I hereby authorize SuperiorView Swallowing Diagnostics to evaluate me under the plan of treatment as authorized by my Physician(s). This evaluation will include the following procedure: Flexible Endoscopic Evaluation of Swallowing. The potential risks associated with this procedure are minimal and rare (occurring in less than 1 % of cases) but include gagging, spasm of the vocal cords, fainting and nose bleed.

I hereby authorize SuperiorView Swallowing Diagnostics and ______________________________ (facility) to release any medical records in its possession concerning my illness and / or evaluations to physicians, hospitals, nursing homes and other medical agencies as necessary. The information in my evaluation may be used for educational purposes and SuperiorView Swallowing Diagnostics will take steps to protect my privacy.

Patient Name: ____

Signed: ____Date:______________
Patient's signature or legal guardian / relationship

Telephone/Verbal Authorization given by: ____________________________________

Relationship to patient: _______________________________Date:______________

Telephone / Verbal Authorization taken by: __________________________________

Facility checklist for FEES exam:

________**1.** Physician order written in chart for "Endoscopic Swallow Eval" or "FEES."

________ **2.** Patient free of contraindications for FEES (facial or maxillary fractures, recent nasal trauma, bilateral nasal obstruction, severe nose bleeds, vasovagal episodes).

________ **3.** Evaluating SLP advised of any infectious diseases, physical/ positioning limitations, isolation precautions, and anticoagulation therapy.

________ **4.** Please indicate payer source for therapy services this date: __________________

Thank you for this referral!