



Permission for Exchange of Information | Receipt of HIPPA

I give permission to exchange medical information, either written or by phone, between my providers of medical and therapeutic services (or those of my child), as well as insurance providers. I understand that the purpose of this exchange is to allow for coordinated services between these providers. I have received the HIPPA information and understand its contents in its entirety.

Name of Patient (printed) _____ Date _____

Signed (responsible) _____ Date _____

Permission to Use Files for Research or Presentation

I give my permission for use of photographs and records made in the process of examination and treatment, to be used for the purposes of research, education and publication in professional journals.

Signed _____ Date _____

Success of Therapeutic Program

“It must be noted that successful completion of the myofunctional therapy program is dependent upon patient desire, good attitude and self-discipline. Parental involvement and encouragement are important and necessary. Only the dedicated participant and cooperation of the patient can guarantee effective swallowing and resting posture results.”

Airway Problems and Their Affects

In order to be successful in this program, the patient must achieve closed mouth resting posture. A clear airway is necessary in order to reach this goal. Patients who have allergies or related nasal airway problems present a high risk that goals will not be attained or may require additional visits to do so.