In an effort to expedite Medicaid/Sooner Care’s requirements for a recent hearing screening it necessary that you take your child to OU Sooner Pediatric Otolaryngology clinic. Please call the number below to make an appointment.

**Take with you:**

1. **This document- It will act as a release of information so we may receive a copy of the screening results to submit to MC/SC.**
2. **Your child’s Medicaid/Sooner Care ID card.**

**OU Sooner Pediatric**

**1200 Children’s Ave #8C**

**OKC, OK 73104**

**271-2662**

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MC ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give OUCP permission to send my audiology report to

(print parent name)

**Speech Link, Inc.** for the purpose of determination and authorization of speech-language therapy services.

**Parent Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax results to: Speech Link, Inc. 405-455-5988**