CAL STATE EAST BAY

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Authorization for Release of Protected Health Information (PHI)

I authorize the Rees Speech, Language and Hearing Clinic, Cal State East Bay to release SPEECH-LANGUAGE-AUDIOLOGY records and information pertaining to

Name of client: _____ Date of Birth: _____

_____
Address City State Zip Code Telephone

to the following: ☐ the client, or

Name: _____ Facility, if applicable _____

_____
Address City State Zip Code Telephone

AUTHORIZATION - Authorizing disclosure of protected private health information, which may include sensitive information about behavioral or mental health, is voluntary**.** You must have legal authority to request information. If you are acting as a legal representative to another individual, you must describe the legal relationship to act for the individual.
DURATION - This authorization shall become effective immediately and remain in effect for one year from the date of signature, unless otherwise indicated below.
REVOCATION - You may revoke this authorization, in writing, at any time. The written revocation will be effective upon receipt, but will not be effective to the extent that the person requesting information or others have acted in reliance upon this authorization.
REDISCLOSURE - You may not lawfully further use or disclose the health information to another unless another authorization is obtained or unless such disclosure is specifically required or permitted by law.
COPIES - You have a right to receive a copy of this release authorization form.
USE OF INFORMATION: The information will be used for the following purposes:

Speech language assessment, therapy, or treatment for related medical conditions.

_____ _____ _____
Printed Name of Person Signing Release Signature Date

_____ _____
Legal Relationship to Client, or ☐ self Expiration Date for Authorization