Norma S. and Ray R. Rees Speech, Language and Hearing Clinic
The Department of Speech, Language, and Hearing Sciences
25800 Carlos Bee Boulevard, MB 1099
Hayward CA 94542-3065 Telephone: (510) 885-3241
Fax: (510) 885-2186 Email: clinic@csueastbay.edu

Authorization for Release of Protected Health Information (PHI)

I authorize Name: ________________________ Facility: __________________________

Street: ________________________ City: _________________ State: ____ Zip: ______

Telephone: ______________________________ Fax: _____________________________

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

____

Name of Client Date of Birth Medical Record Number

____

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 - We 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/hearing evaluation and/or therapy at the Rees Clinic.

____________________________________ ______________________ ___________

Printed Name of Person Signing Release Signature Date

______________________________ ____

Legal Relationship to Client Expiration Date for Authorization

If left blank, this will be one year from the date signed.