College of Letters, Arts, and Social Science

Has the prospective client had any previous speech, language or hearing $\underline{\text{evaluations}}$ YesNo	or treatment?
If YES, do you have a copy of the most recent IEP or medical report?YesNo	

If you checked "Yes" above, please provide a copy of the IEP or medical report. If you checked "No" above, please complete the Authorization for Release of Information form included with this application (page 4), and we will request the report(s) on your behalf. Your application will not be able to be processed without these documents . Additionally, please provide the information below:

	Provider	Dates of Service	Outcome/Recommendations
EvaluationTreatment			

. . .

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 Email: clinic@csueastbay.edu

Authorization for Release of Protected Health Information (PHI)

I authorize Name:	Facility:				
Street:	City:		State:	Zip:	
Telephone:	Fax: ˌ				
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	Date of Birth		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 ()Tj-0.000uTa26.40uWhllst (e)17e)ega10a0thbTrilyst664equest qhfbTriladbnTjif0y009aTe26fin6asT[-A)0 a legal representative to another individual, you must describe the legal relationship to act for the individual.

DURATION - This authorization shall become in the first of the content of the con