CAL STATE EAST BAY

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,