Valdosta State University
Speech and Hearing Clinic

229-219-1301 (Office) 1500 N. Patterson St., Valdosta, GA 31698 229-219-1302 (Fax)

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

TO: _____

Name of the Healthcare Provider/Physician/Facility

_____

Street Address

_____

City, State, and Zip Code

RE: Client's Name: _____

Client's DOB: _____

I authorize and request the release of the checked below information to the Valdosta State University Speech and Hearing Clinic. This information is needed to assist with planning and implementing a treatment program to help remediate the above client's communication/swallowing/voice disorder.

□ Medical Reports	□ X-Rays (MRI's, CAT Scans)
□ Evaluation Reports: □ Aud. □ SLP □ _____	□ Treatment Notes: □ Aud. □ SLP □ Nursing
□ Entire record, excluding information that is prohibited by law (e.g., test protocols)	
□ Other:	

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

_____

Name and Relationship of Legally Authorized Representative to Patient