SDSU College of Health and Human Services
School of Speech, Language, and Hearing Sciences

AUTHORIZATION TO SECURE INFORMATION FROM OUTSIDE AGENCY

I AUTHORIZE: _____
(Name of Outside Agency)

_____
(Address of Outside Agency)

_____

_____Speech Pathologist _____School _____Hospital _____Physician _____Audiologist

TO RELEASE INFORMATION TO: THE SAN DIEGO STATE UNIVERSITY SPEECH-LANGUAGE/AUDIOLOGY CLINIC REGARDING:

_____

_____
(Name of Client) (Date of Birth)

THE INFORMATION IS REQUESTED FOR:

_____	Speech-Language Diagnostic Evaluation	_____	Education of the Deaf
_____	Speech/Language Intervention	_____	Research Purposes
_____	Audiological Evaluation	_____	School Visit

SPECIFIC TYPE OF INFORMATION TO BE RELEASED:_____

_____

- The information requested above will be held in strict confidence and utilized only for the specific reason stated above. The authorization for release of the above information to the San Diego State University Speech-Language/Audiology Clinic will expire one year from the date this form is signed.
- I understand that this authorization is voluntary.
- I have the right to revoke this authorization by sending a notice stopping this authorization to the Speech-Language/Audiology Clinic at the address listed below. The authorization will stop on the date my request is received.
- I understand that the San Diego State University Speech-Language/Audiology Clinic is not a health plan or health care provider, and the released information may no longer be protected by federal regulations.
- I understand that I have the right to receive a copy of this authorization.

_____
Patient/Parent or Guardian Date

_____
Witnessed Date

Please send information to: San Diego State University
Speech-Language Clinic
5500 Campanile Drive
San Diego, California 92182-1518
FAX: 619-594-7790 or 619-594-5917