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: ________________

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Address City State Zip Code Telephone

to the following: the client, or

Name: ____________________________ Facility, if applicable ___________________________

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Address City State Zip Code Telephone

AUTHORIZATION - Authorizing disclosure of protected private health information,