SPEECH & HEARING CLINIC
UNIVERSITY of WASHINGTON

RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____

The University of Washington Speech & Hearing Clinic is hereby given permission to send summaries of the speech-language and/or hearing evaluations, treatment notes, and/or treatment progress summaries to the individuals listed below. Additionally, I give my permission for the following agencies and/or professionals to release medical/educational information to the University of Washington Speech & Hearing Clinic. I understand that the information will be treated in a confidential manner per this agreement.

Please enter names, addresses, and fax numbers. Check if we are to send information to, or receive information from, each person listed.

Send to ☐ Receive from* ☐

Name:_____ Fax: _____

City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Name:_____ Fax: _____

City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Name:_____ Fax: _____

City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Name:_____ Fax: _____

City: _____ State: _____ Zip Code: _____

*Please provide records for time period of ____ / ____ / ____ through ____ / ____ / ____.

_____ _____

Signature of Client or Person Responsible for Care **Date of Signature**

Consent for release of medical records/confidential information is valid for ninety (90) days from the date of signature.

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