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 provide the organization name, ATTN to, address, and fax number for each entry. Check the box to indicate whether we can send information to and/or receive information from each organization below.

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN: _____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN:_____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN: _____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization: _____ Fax: _____

ATTN: _____ 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 365 days from the date of signature.

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