AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize **Valdosta State University Speech and Hearing Clinic**, Valdosta, GA, to use or disclose the above

Evaluation Reports: Aud. SLP Date(s):	Treatment Notes: Aud. SLP Date(s):
Entire record, excluding information that is prohibited by law (e.g., test protocols)	
Other (Please specify date(s) of service or specific information):	

Please mail copy to my home address.

Please mail the copies to the following school/medical addresses listed below.

This information may be disclosed to and used by the following individual or organization:

Name/Organization: _____

Address: _____City: _____State: _____ Zip Code:_____

Purpose of disclosure: At the request of the individual Other: _____

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits are NOT conditioned on my signing this Authorization. However, The Speech and Hearing Clinic may condition the provision of healthcare for the purpose of disclosing to a third party protected health information specifically createenavc( )o(h)1inga cr5inga thelltpar20(