VALDOSTA STATE UNIVERSITY

Valdosta State University
Speech and Hearing Clinic

229-333-5931 (Office) 1500 N. Patterson St., Valdosta, GA 31698 229-219-1335 (Fax)

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Client's Name: _____ **Client's DOB:** _____

Parent's Name (if client is a minor): _____ **Clinic Number:** _____

I authorize **Valdosta State University Speech and Hearing Clinic**, Valdosta, GA, to use or disclose the above named client's protected health information. The following information is to be disclosed:

□ 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 the 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 created for that third party, or for participating in research-related treatment upon my agreement to use and disclose this information.

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to The Speech and Hearing Clinic to disclose my records, and that I may revoke this Authorization at any time by providing a written notice to The Speech and Hearing Clinic to the attention of the Clinic Director, except if this Authorization was obtained as a condition of obtaining insurance coverage. In order for the revocation of this authorization to be effective, The Speech and Hearing Clinic must receive the revocation in writing.

The revocation shall be effective except to the extent that The Speech and Hearing Clinic has already used or disclosed information in reliance on the Authorization. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. **Please refer to the *Notice of Health Information Privacy Practices* for more detailed information.** Unless otherwise revoked, this authorization will expire one year from the date of signature or in less than a year, as indicated: _____. After this date, The Speech and Hearing Clinic can no longer use or disclose the client's protected health information without first obtaining a new authorization form.

- **I fully understand and accept the terms of this authorization.**

  Signature _____ Date _____

- **The above authorization is given on this client's behalf as the client is a minor or is unable to sign for the following reasons:** _____

  Signature: _____ Date _____
  Relative / Guardian / Personal Representative