California State University, Long Beach
Speech and Language Clinic
1250 Bellflower Blvd. MS 2501
Long Beach, CA 90840
Office: (562) 985-4583

Authorization for Release of Information

I, ________________________________ (client/guardian/caregiver), authorize

____ to release verbal and/or

written information regarding the client, ____,

to the following person/agency.

Name ____

Daytime Phone #: ____

Email: ____

Address: ____

City: ________________________________ State: __________ Zip Code: ____________

The information will be used for the following purposes:

- ☐ At my (patient's) request
- ☐ Assessment
- ☐ Billing purpose
- ☐ Therapy planning
- ☐ Generalization of therapeutic skills
- ☐ Coordination of services through the Stephen Benson Program
- ☐ Other: ____

Information requested for the past _______ months:

- ☐ Individualized Education Plan (IEP)
- ☐ Assessment Report
- ☐ Therapy Plan (Goals & Objectives)
- ☐ Progress Report
- ☐ Transcript
- ☐ Medical Reports
- ☐ Therapy Notes/SOAP notes
- ☐ Other: ____

1. I understand that this authorization expires after one year.
2. I understand that I can revoke this authorization at any time without affecting my enrollment in the clinic, payment, or treatment.
3. Authorization can be revoked by submitting a written letter to the clinic assistants. This letter must be signed and dated by the client or representative. This authorization will cease to be effective on the date notified except if the information has already been released.
4. I understand the potential for information disclosed at my request may be redisclosed by the recipient.

By signing below, I acknowledge that I have read and understand this authorization.

Signature: ________________________________ Date: ______________________

Printed Name: _____________________________

Relationship to Client: ________________________