

## **Authorization for Release of Protected Health Information (PHI)**

I authorize the Rees Speech, Language and Hearing Clinic, Cal State East Bay to release SPEECH-LANGUAGE-AUDIOLOGY records and information pertaining to

Name of client:	Date of Birth:				
Address		City	State	Zip Code	Telephone
to the following: t	he client, or				
Name:	Facility, if applicable				
Address		City	State	Zip Code	Telephone
AUTHORIZATION - Authorizing disclosure of protected private health information,					