Indiana University Speech, Language and Hearing Clinic
Authorization for Exchange of Health Information/Release of Patient Information

Health Sciences Building, Room C2122
2631 East Discovery Parkway
Bloomington, IN 47408
FAX: (866) 981-1874

Patient/Client Name:_____ **DOB:**_____
Last First MI

Address:_____

City:_____ **State:**_____ **Zip:**_____

I hereby authorize the IU Speech, Language and Hearing Clinics to exchange my health information with the following professionals or agencies as indicated below:

Send To:	**Receive From:**		
_____	_____	_____	_____
		Professional or Agency	**Fax Number**
_____	_____	_____	_____
		Professional or Agency	**Fax Number**
_____	_____	_____	_____
		Professional or Agency	**Fax Number**
_____	_____	_____	_____
		Professional or Agency	**Fax Number**

Information to be released: Dated: from _____to _____
(Example: from January 1, 2018 to present)

____ Medical History/Treatment/Physicals
____ Medical/Surgical Records
____ Medications
____ Progress Notes
____ Academic Records IEP/IFSP
____ Audiologic Information
____ Speech-Language Pathology Reports
____ Consultations

I specifically authorize the release of information relating to:

___ Substance abuse (including alcohol/drug abuse)
___ Mental health (including psychotherapy notes)
___ HIV related information (including AID and Communicable disease related testing)

X _____ _____
Signature of patient or legal guardian **Date**

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I hereby authorize you to release and talk about my medical record and billing with persons listed below: (Example: partner, family member, parent (if client is 18 or older)

Name: _____

Address:_____

City: _____**State:** _____ **ZIP:**_____

Phone: _____

____ Talk with person about my medical information

____ Talk with person about my accounting information

1. I understand that this authorization will expire 180 days from the date signed unless otherwise specified here: _____.
2. I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to the above-named authorized entity. The revocation will not apply to information that has already been released in response to this authorization.
3. I understand that information used to disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
4. I understand that I am not required to sign this Authorization in order to receive health care treatment.

X _____ _____

Signature of patient or legal guardian **Date**

UPDATED: April 2021