College of Health Solutions
Arizona State University

Speech and Hearing Clinic
PO Box 870102
Tempe, AZ 85287-0102

(480) 965-2373
Facsimile
(480) 965-0076

Speech and Hearing Clinic

Release-Of-Information Authorization

I, _____, date of birth: _____
(print your name)

do hereby authorize the Arizona State University Speech and Hearing Clinic to receive the following:

- ☐ Audiological Evaluations including:
  a. audiograms
  b. aided testing (functional gain, probe microphone measures, and/or aided speech testing)
  c. electroacoustic information for the hearing aid(s)
- ☐ Other (please specify)_____

PLEASE SEND RECORD TO THE FOLLOWING MEDICAL OFFICE
DOCTOR'S/PROVIDER'S NAME _____

ADDRESS: _____

_____

_____

TELEPHONE: _____

FAX: _____

I understand that these records will remain confidential and will be used only in relation to services received through the Arizona State University Speech and Hearing Clinic. This authorization is valid for one calendar year. I understand that I have the privilege of revoking this at any time, providing I submit written notice. However, this will not affect information released prior to revocation.

_____ _____
Client's Signature Date