California State University, Fresno
Speech, Language and Hearing Clinic
5310 North Campus Drive M/S PH 80
Fresno, California 93740-8019
(559) 278-2422 ◆ Fax (559) 278-5187

RELEASE OF CLINICAL INFORMATION ***FROM*** THE SPEECH, LANGUAGE, AND HEARING CLINIC

Today's Date: _____

Name of Client: _____ DOB: _____

Release of information *to:*

Facility/Person Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

FAX Number: _____

I, _____ hereby give the Speech, Language, and Hearing Clinic at California State University, Fresno, permission to release clinical information regarding any speech, language, or hearing diagnosis or treatment concerning _____ that occurred between the dates of _____ and _____to the appropriate medical and educational agencies to further his or her care and education.

This release is considered valid for one year from the date it is signed below.

_____ _____

Parent/Guardian/Self (18 or older) **Date**