INDIANA UNIVERSITY

Robert L. Milisen Speech-Language & Hearing Clinics

Authorization to Release and Disclose Patient Information

PATIENT/CLIENT NAME: _____ DATE OF BIRTH: _____
LAST FIRST MI MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I HEREBY AUTHORIZE Robert L. Milisen Speech-Language & Hearing Clinics to release my information to the person/provider listed below:

❑ Me ❑ Family/Friend ❑ Other

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ FAX NUMBER: _____

INFORMATION TO BE RELEASED: Dated: from _____ to _____ *(Example: from January 1, 2018 to present)*

- ☐ Medical history/treatment/physical
- ☐ Medical/Surgical Records
- ☐ Medications
- ☐ Consultations
- ☐ Progress Note
- ☐ Speech-Langauge Pathology Reports
- ☐ Audiologic Information

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

RELEASE INSTRUCTIONS: RELEASE METHOD/FORMAT REQUESTED: (CHECK ONE)

☐	Electronically – via email	Email Address:
☐	Paper Records	☐ Pick Up in Office ☐ US Mail to address listed above
☐	Fax – Patient Care Only	Fax Number listed above

☐	Personal Use*	☐	Insurance application*	☐	Litigation/Legal*
☐	Continuing Care	☐	Transfer of Care	☐	Insurance Payment/Claim
☐	Other *				

* Fees may be charged in accordance with Indiana Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. §164.524

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 or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

_____ _____ **OR** _____ _____

SIGNATURES: CLIENT DATE PARENT/LEGAL GUARDIAN DATE

_____ _____

PRINT: RELATIONSHIP TO CLIENT NAME OF PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON