INDIANA UNIVERSITY

Robert L. Milisen Speech-Language & Hearing Clinics

Authorization for Exchange of Health 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 exchange my health information with the following professionals or agencies as indicated below:

Send To	Receive From		
❑	❑	Professional or Agency	Fax #
❑	❑	Professional or Agency	Fax #
❑	❑	Professional or Agency	Fax #
❑	❑	Professional or Agency	Fax #
❑	❑	Professional or Agency	Fax #

INFORMATION TO BE RELEASED: Dated: from_____ to _____

(Example: from January 1, 2018 to present)

- ☐ Medical history / treatment / physicals
- ☐ Medical / Surgical Records
- ☐ Medications
- ☐ Consultations
- ☐ Progress Notes
- ☐ Speech-Language Pathology Reports
- ☐ Academic Records IEP/IFSP
- ☐ 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

1. I understand that this authorization will expire 180 days days (6 months) 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 Linda McNabb, Indiana University. The revocation will not apply to information that has already been released in response to this authorization.
3. I understand that I am not required to sign this Authorization in order to receive health care treatment.
4. 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.

SIGNATURES:

_____ _____ OR _____ _____

CLIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

PLEASE PRINT

_____ _____

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