

Authorization for Obtaining Information

I, the undersigned, do hereby authorize the University of Arizona Speech-Language and Hearing Clinics to obtain information from, including pictures, audio or video tapes, any agency or individual who is, or may be directly involved in the examination, treatment and/or recommendations concerning the following client/patient. I also understand that I have the right to revoke this authorization in writing at any time.

Client/Patient _____ DOB: _____

Date: _____

Address: _____
(Street) (City, State, Zip)

Telephone: _____

Authorized by: _____
(Signature) (Printed)

Relationship to Client/Patient: _____

Address if different than client/patient: _____

Witness: _____ Date: _____

Semester: _____

The following individual or agency is authorized to release the client/patient information to:

**Child Language Center
Wings on Words Preschool and Kindergarten
202 E. Speedway
Tucson, AZ 85705**

Name & Address	Information to be released, i.e., speech evaluations or audiograms