The Child Language Center

Authorization to Release Information

I, the undersigned, do hereby authorize the University of Arizona Speech Language and Hearing Clinics, on behalf of The Child Language Center, to release information as stipulated below, including pictures, audio or video tapes, to any agency or individual who is, or may be directly involved in the examination, treatment and/or recommendations concerning my child.

Today's Date:_______________________________

Client/Patient:____DOB:_________________

Home address:____
(street) (City, State, Zip)

Telephone:________________________________ email address:____________________________

Place initials to permit or deny release of information:

Type of Info	Yes	No
Written reports		
Pictures		
Audio tapes/Digital recordings		
Video tapes/Digital recordings		

Authorized by:____________________________________Signature:_______________________________

Relationship to client/patient:____

Address if different than client/patient:____

Witness:____Signature:______________________________