College of Letters, Arts, and Social Science

Has the prospective client had any previous speech, language or hearing evaluations or treatment?
…Yes …No

If YES, do you have a copy of the most recent IEP or medical report?
…Yes …No

If you checked "Yes" above, please provide a copy of the IEP or medical report. If you checked "No" above, please complete the Authorization for Release of Information form included with this application (page 4), and we will request the report(s) on your behalf. Your application will not be able to be processed without these documents . Additionally, please provide the information below:

	Provider	Dates of Service	Outcome/Recommendations
…Evaluation …Treatment			
…Evaluation …Treatment			
…Evaluation …Treatment			
…Evaluation …Treatment			

…

Norma S. and Ray R. Rees Speech, Language and Hearing Clinic
The Department of Speech, Language, and Hearing Sciences
25800 Carlos Bee Boulevard, MB 1099
Hayward CA 94542-3065 Telephone: (510) 885-3241
Email: clinic@csueastbay.edu

Authorization for Release of Protected Health Information (PHI)

I authorize Name:_____ Facility: _____

Street:_____ City:_____ State:_____ Zip: _____

Telephone:_____ Fax: _____

to release to the Rees Speech, Language and Hearing Clinic, Cal State East Bay SPEECH-LANGUAGE-AUDIOLOGY records and information pertaining to

Name of Client Date of Birth Medical Record Number

Address City State Zip Code Telephone

AUTHORIZATION - Authorizing disclosure of protected private health information, which may include sensitive information about behavioral or mental health, is voluntary. You must have legal authority to request information. If you are acting as a legal representative to another individual, you must describe the legal relationship to act for the individual.

DURATION - This authorization shall become effective immediately