UNIVERSITY OF CENTRAL OKLAHOMA

College of Education and Professional Studies
Department of Special Services
Speech Language Pathology

RELEASE OF INFORMATION

I, _____authorize the release of information
(First name) (Last name)

for _____ _____
(Client's first name) (Client's last name) (Birthdate)

in regard to speech-language-hearing assessment and/or treatment or _____

_____

_____
(other medical or educational information)

_____*FROM* _____*TO* *University of Central Oklahoma Speech and Hearing Clinic*
100 N. University Dr.
Edmond, OK. 73034
Attention: Clinic Coordinator
Phone: 405-974-5403; Fax: 405-974-3966

_____*FROM* _____*TO* _____
(name or agency)

_____
(department, building or address)

_____
(phone or fax)

_____ _____
(Authorizing Signature) *(Date)*

_____
Date release sent