FSU | L.L. SCHENDEL SPEECH & HEARING CLINIC
COMMUNICATION SCIENCE & DISORDERS

REQUEST FOR RELEASE OF PERSONAL INFORMATION

TO:_____

_____

_____

_____

_____

I hereby request and authorize you to release to the FSU Speech and Hearing Clinic the following medical, social, psychiatric, psychological, or educational information:

_____

(Identity in this space the specific information to be released)

Full name: _____

Address: _____

_____

Date of Birth: _____

Treatment _____

_____ _____

Client/Client's Parent or Guardian signature **Date**

Mail records to :

FSU Speech and Hearing Clinic
201 West Bloxham Street
Tallahassee, FL 32301-1200