Widener University
Institute for Speech-Language Pathology
College of Health and Human Services

AUTHORIZATION TO RELEASE CLINICAL RECORDS

Name of Client: _____ Phone: _____

Date of Birth: _____

I authorize the SLP Clinic to release all clinical records to the following individuals:

Name:_____ Phone:_____
Address:_____ City, State, Zip:_____
Relationship:_____

Name:_____ Phone:_____
Address:_____ City, State, Zip:_____
Relationship:_____

Name:_____ Phone:_____
Address:_____ City, State, Zip:_____
Relationship:_____

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient is not required by law to protect the privacy of the information.*

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.*

_____ _____
Signature Date

_____
Name (Print)

_____
Relationship to Client

*This authorization expires upon discharge from services.