LAMAR UNIVERSITY

**Request for Release of Information**
**(from other to LU clinic)**

**Speech & Hearing Clinic**
**Lamar University**
**P.O. Box 10076**
**Beaumont, Texas, 77710**

Releasing Agency:
_____

Address: _____

_____

_____

I, _____, authorize and request that you release to the Speech & Hearing Clinic, Lamar University, Attn: _____ the following information [list specific items] concerning _____,

birthdate _____:

I understand that these records are protected under the Federal Confidentiality Regulations (42CFR, Part 2), and cannot be disclosed without my signed consent unless otherwise provided for in the regulations. When such records of the undersigned are released in accordance with the above-stated provisions, the agency releasing the information and its personnel shall be free from all civil and criminal liability.

_____ _____
(Signature of Client or Parent) (Date)

_____ _____
(Signature of Witness) (Date)

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Date Requested: _____ Date Received: _____