Longwood University 201 High Street Farmville, VA 23909

**Physical Office Location: 315 West Third Street Farmville, VA 23901 Mailing Address: PO Box 513 Farmville, Va 23901**

Phone (434) 395-2972 – Fax (434) 395-2622

[shls@longwood.edu](mailto:shls@longwood.edu)

# AUTHORIZATION FOR DISCLOSURE and REQUEST of PROTECTED HEALTH INFORMATION

## Client Name: Date of Birth: Address:

City: State: Zip Code: Phone Number:

1. I authorize the disclosure, request or use of the above named individual’s information as described below:
2. Longwood University’s Speech, Hearing, and Learning Services, 315 West Third Street, Farmville, VA, 23901, is authorized to disclose and/or request my medical or other specified information, as described below:
3. The type and amount of information to be disclosed, requested or used is as follows: (include dates where appropriate):

|  |  |
| --- | --- |
| Type of Information | From (date): |
| Speech-language records: |  |
| Audiological Evaluation |  |
| Hearing Aid Information |  |
| Auditory Processing Evaluation |  |
| School Records (Psychological, Educational, Speech-language, etc.) |  |
| Other (must specify) |  |

1. If this authorization is for release of medical records, I understand that I am giving my permission to release copies of information in my medical record that may include information relating to mental health, substance abuse, AIDS/HIV testing or treatment of sexually transmitted disease, unless indicated in the following

instructions:

1. This information may be disclosed to, requested from or used by to the following individual(s) or organization(s): (If the client or representative is requesting this release of information, s/he may fill in this blank with “at the request of the individual”)

# Name Address

**Telephone Number: Fax Number:**

**For the purpose of**

* + **Name Address**

**Telephone Number: Fax Number:**

**For the purpose of**

1. I understand that the information disclosed to the above individual or organization may be disclosed again and not be protected by the federal Privacy Rule. If I have questions about disclosure of my health information, I may contact Longwood University’s Speech, Hearing, and Learning Services.
2. I understand to Longwood University’s Speech, Hearing, and Learning Services cannot condition its provision of services on whether or not I sign this authorization, unless I am requesting care specifically for it to be disclosed under this authorization (for example, an evaluation for use by another agency).
3.  If I check this box, the individuals or organizations named in sections 2 and 5 above may each disclose the information described in section 3 to each other, for the purpose described in section 5. I understand that I will need to write to all those individuals and organizations in order to revoke this authorization.
4. I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing to Longwood University’s Speech, Hearing, and Learning Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in one (1) year from the date signed, unless an expiration date, event or condition is specified as follows:

\_ (**SIGNATURE REQUIRED on BACK)**

# THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

**Date:**

***Printed Name of Client or Legal Representative***

**Date:**

***Signature of Client or Legal Representative***

***If Signed by Legal Representative, Describe Authority to Act on Client’s Behalf***