LAMAR UNIVERSITY

Release of Information
(from LU clinic to others)

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

I, _____, authorize and request that you release the following information

[list specific items] concerning _____,

birthdate _____:

Release to:
_____

Address:_____

_____

_____

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 Sent: