AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize **Valdosta State University Speech and Hearing Clinic**, Valdosta, GA, to use or disclose the above

Evaluation Reports: Aud. SLP Date(s):	Treatment Notes: Aud. SLP Date(s):
Entire record, excluding information that is prohibited by law (e.g., test protocols)	
Other (Please specify date(s) of service or specific information):	

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