

INDIANA UNIVERSITY
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OUTPATIENT CONSENT TO EXCHANGE INFORMATION

Client's Name: _____ D.O.B. _____
Address: _____

I _____, hereby authorize the Robert L. Milisen Speech-Language & Hearing Clinics to exchange information with the following professionals or agencies.

Send To	Receive From		
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
		Professional or Agency	Address
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
		Professional or Agency	Address
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
		Professional or Agency	Address
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
		Professional or Agency	Address
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
		Professional or Agency	Address

Information to be exchanged:

- | | |
|---|---|
| <input type="checkbox"/> Medical/Surgical Records | <input type="checkbox"/> Psychological Report |
| <input type="checkbox"/> Most Recent Physician Notes | <input type="checkbox"/> Academic Records |
| <input type="checkbox"/> Physician History & Physical | <input type="checkbox"/> IEP/IFSP |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Hearing Specialist Reports |
| <input type="checkbox"/> Speech-Lang. Path. Reports | |

Signed: _____ Date: _____

Relationship to Client: _____

