

**UNIVERSITY OF WASHINGTON  
SPEECH AND HEARING CLINIC  
4131 15<sup>th</sup> Avenue N.E.  
Seattle, WA 98105  
Telephone: (206) 543-5440  
Fax: (206) 616-1185**

**AUDIOLOGY: MUTUAL EXCHANGE OF INFORMATION**

Please list the professionals who have provided your most recent health care.

This release is good for ninety (90) days from the date below and must be renewed for use beyond that time. By signing this release, I understand that I will be notified of any other requests for information that are received by this office, in order to give my permission to release information on the named individual. I understand this information will be shared for professional use only and confidentiality will be maintained. I may revoke this release in writing at any time.

**Professional Seen**

**Agreement for Mutual  
Exchange of Information**

**Please provide accurate name(s) and full address.**

Audiologist:

Name \_\_\_\_\_  
Facility \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_

Hearing Aid Dispenser (if different from Audiologist):

Name \_\_\_\_\_  
Facility \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_

Physician Ear Specialist (Otologist) or Primary Health Care

Physician:

Name \_\_\_\_\_  
Facility \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_

I hereby give my permission for the mutual exchange of information between this professional and the University of Washington Speech & Hearing Clinic regarding the records of:

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Signature \_\_\_\_\_  
Signature Date \_\_\_\_\_

I hereby give my permission for the mutual exchange of information between this professional and the University of Washington Speech & Hearing Clinic regarding the records of:

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Signature \_\_\_\_\_  
Signature Date \_\_\_\_\_

I hereby give my permission for the mutual exchange of information between this professional and the University of Washington Speech & Hearing Clinic regarding the records of:

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Signature \_\_\_\_\_  
Signature Date \_\_\_\_\_