



**SAN JOSÉ STATE
UNIVERSITY**

Request for Information Form

Client Name: _____ Date of Birth: _____

Address: _____ SSN: _____

Phone Numbers: Home _____ Work _____

Email: _____

I hereby authorize the Kay A. Armstead Center for Communication Disorder to obtain any and all speech, language, and hearing diagnostic/therapy information on the above named individual from the person or agencies listed below.

Name: _____ Title: _____

Facility: _____

Address: _____

Name: _____ Title: _____

Facility: _____

Address: _____

Client Name (Please Print)

Date

Signature

Relationship

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