LAMAR UNIVERSITY

Designation of Individuals Who are Involved in
My Payment or Treatment Decisions*

I hereby authorize employees of the Lamar University Speech & Language Clinic to disclose my protected health information held by the clinic and related to treatment or payment for health services received, to individual(s) who are involved in my treatment and/or payment and who I have indicated below.

Please enter the information requested and check the appropriate box to indicate whether the individual is involved in your payment and/or treatment decisions.

Individual's Full name (Please print)	Relationship to Patient	Involved in Payment (Check yes or no)	Involved in Treatment (Check yes or no)

This information will be presumed valid and the Clinic may rely on it until you have notified the Clinic in writing of the modification. Notification of a change in the above information provided by you should be sent to the Appointment Secretary at the address below:

Clinic Secretary
Lamar University
P.O. Box 10076
Beaumont, Texas 77710

_____ _____

Patient or Legal Representative Signature Date

***File form in patient chart**