LAMAR UNIVERSITY

LAMAR UNIVERSITY SPEECH & HEARING CLINIC
Policies, Procedures, Informed Consent and Authorization for use and Disclosure of Protected Health Information for Clinical or Education Purposes

I, _____, hereby consent to consultation, evaluation, habilitation/rehabilitation and other services as may be provided to me and/or my family by the Lamar University Speech & Hearing Clinic. I understand that I may withdraw this consent for treatment at any time.

I understand that the Lamar University Speech & Hearing Clinic provides services through the use of clinical teams. Each team is composed of a clinic staff member, student clinician(s) and such other consultative staff as may be indicated. All clinic faculty members hold a Texas License and a Certificate of Clinical Competence in Speech-Language Pathology and/or Audiology awarded by the American Speech-Language-Hearing Association and are directly responsible for patient care and supervision. I further understand that said services may be observed for educational and/or research purposes by visual and/or electronic means. Confidentiality of information will be honored, except where I have authorized the release of my information in advance.

I have been advised of any alternatives to these speech habilitative or rehabilitative services, and I have also been advised of the relative risks or benefits of these services.

I have been informed of the training and credentials of the clinicians providing services to me. By signing this, I am consenting and agreeing only to those services that the clinician working with me is qualified to provide within:

a) the scope of that clinician's license, certification and training; or
b) the scope of license, certification and training of clinicians directly supervising the services received by me.

Although we provide information on how to reach us electronically, we do not provide services via e-mail, and we discourage you from sending us any confidential information by e-mail. Please remember that e-mail is not a confidential mode of communication, and we ask that you contact us by phone if privacy is essential.

I hereby authorize the Lamar University Speech & Hearing Clinic and its employees to use and disclose my protected health information, including medical records, audiotapes and videotapes created during services provided to me for clinical or educational purposes only. I understand that this authorization is limited to the uses and disclosures described below.

Information derived from evaluation, habilitation/rehabilitation and other services provided by the Lamar University Speech & Hearing Clinic may be used and disclosed by clinical and other personnel for purposes of clinical review, training, classroom discussions, and other educational uses. The purpose of this authorization is to permit interns, students of Audiology and Speech-Language Clinics and other health care providers who are participating in clinical or similar educational training to review and discuss my case with instructors and other students for educational purposes only. The information to be shared will be limited to the facts of my case, treatment, and possible alternatives, habilitation/rehabilitation services, video and audiotapes. I further understand that reasonable steps will be taken to protect my name, address and student or other identification number from disclosure.

I understand that clinical professors and other health care professionals reviewing my information are typically bound by ethical requirements to maintain the confidentiality of medical and treatment information. However, I understand that upon disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the

recipient and may no longer be protected by federal privacy regulations.

I understand that the Lamar University Speech & Hearing Clinic will not deny treatment to me based upon whether I sign this authorization, and I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to the Lamar University Speech & Hearing Clinic. The revocation will be effective upon receipt by the University, except to the extent that the University has taken action in reliance on this authorization. I further understand that this authorization will expire one hundred eighty (181) days from the Signature Date, unless I specify a different expiration date or event here: _____. After the expiration date, this authorization will no longer be effective, and no further information will be furnished pursuant to it.

I understand and agree to all practices noted above, and consent to the services described above.

Signed _____ Relationship to Patient: _____
Patient or Legal Representative

_____ Signature Date_____
Printed name if not Patient

Witness_____

Patient was offered a copy of this form and declined

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received and/or read the Notice of Privacy Practice.

Patient or legal Representative_____
Signature