FSU | L.L. SCHENDEL SPEECH & HEARING CLINIC
COMMUNICATION SCIENCE & DISORDERS

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Client's Name: _____ **Client's DOB:** _____

Parent's Name (if client is a minor): _____ **Clinic Number:** _____

PHONE NUMBER ***EMAIL:***

_____

LEAVING MESSAGES

Can messages regarding your appointment(s) be left on your answering machine/voicemail? ___ Yes ___ No

AUTHORIZATION TO COMMUNICATE VIA EMAIL and TEXT Messages

Transmitting confidential patient information by email has a number of risks that clients should consider before using email.

I authorize the clinic to contact me via email/text message about my appointments. ___ Yes ___ No

I authorize the clinic to send reports or other documents via email. ___ Yes ___ No

I authorize **The Florida State University Speech and Hearing Clinic**, Tallahassee, FL, to use or disclose the above named client's protected health information. The following information may be disclosed: Please indicate preference with an X

-----Audiological records ------Speech records -----Any/all records.

Name/Relationship _____Phone #_____

Address: _____ City: _____ State: _____ Zip Code: _____

Indicate report mailing preference: E-MAIL or REGULAR MAIL

Name/Relationship: _____Phone #_____

Address: _____ City: _____ State: _____ Zip Code: _____

Indicate report mailing preference: E-MAIL or REGULAR MAIL

Name/Relationship: _____Phone #_____

Address: _____ City: _____ State: _____ Zip Code: _____

Indicate report mailing preference: E-MAIL or REGULAR MAIL

Name/Relationship: _____Phone #_____

Address: _____ City: _____ State: _____ Zip Code: _____

Indicate report mailing preference: E-MAIL or REGULAR MAIL

_____I will pick up the copies myself (Please bring picture ID to pick up.)

If additional authorizations are needed, please fill out another sheet.

ACCREDITATION

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT conditioned on my signing this Authorization. However, The Speech and Hearing Clinic may condition the provision of healthcare for the purpose of disclosing to a third party protected health information specifically created for that third party, or for participating in research-related treatment upon my agreement to use and disclose this information.

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to The Speech and Hearing Clinic to disclose my records, and that I may revoke this Authorization at any time by providing a written notice to The Speech and Hearing Clinic to the attention of the Clinic Director, except if this Authorization was obtained as a condition of obtaining insurance coverage. In order for the revocation of this authorization to be effective, The Speech and Hearing Clinic must receive the revocation in writing.

The revocation shall be effective except to the extent that The Speech and Hearing Clinic has already used or disclosed information in reliance on the Authorization. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. **Please refer to the *Notice of Health Information Privacy Practices* for more detailed information**. Unless otherwise revoked, this authorization will expire one year from the date of signature or in less than a year, as indicated: _____. After this date, The Speech and Hearing Clinic can no longer use or disclose the client's protected health information without first obtaining a new authorization form.

- **I fully understand and accept the terms of this authorization.**

  Signature _____ Date _____

- **The above authorization is given on this client's behalf as the client is a minor or is unable to sign for the following reasons:** _____

  Signature: _____ Date _____
  Relative / Guardian / Personal Representative

For Office use only: **Processed by: _____ Date: _____**