Saint Xavier UNIVERSITY
Ludden Speech and Language Clinic

CONSENT TO OBTAIN OR FURNISH PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City_____ State_____ ZIP _____

I hereby authorize Ludden Speech Clinic to **DISCLOSE (give a copy)** of my confidential, protected health information to:

Name _____

Fax Number _____

OR

I hereby authorize Ludden Speech Clinic to **OBTAIN (request a copy)** of my confidential, protected health information from:

Name _____

Fax Number _____

Information Requested (choose all that apply):

- ❑ Diagnostic Report
- ❑ Medical Records
- ❑ Therapy Notes
- ❑ Other_____

Authorization:

I understand the risks and procedures involved with using electronic communication to request and obtain protected health information. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of email and facsimile as one form of communication with my clinician, and his/her associates, technicians and other health care workers.

Duration of Consent and right of Revocation: I understand this authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization. This authorization form is valid until one year after signing, unless otherwise specified. I reserve the right to revoke the consent at any time. I understand that the Ludden Speech Clinic may not condition treatment or payment upon my executing this authorization. In an emergency situation where I am lacking the capacity to give informed consent, when a delay in treatment could result in serious disability or death; I understand that my patient information may be disclosed or obtained as necessary to the appropriate officials who are seeking to address my needs to protect my health and safety.

_____ _____

Signature of Client/Parent/Legal Guardian (if <18 years old) Date

If Parent/Guardian - relationship to Client: _____