RELEASE OF INFORMATION FORM

I hereby authorize The Pauline K. Winkler Speech-Language-Hearing Center to release or obtain information relevant to my (my child's) communication problem. I understand that the Information to be released or obtained is confidential and protected from disclosure within appropriate guidelines. I also understand that I have the right to cancel my permission to release information at any time.

My consent to release or obtain information will expire when acted upon, or 90 days from this date, whichever occurs first.

Date: Click or tap here to enter text.

Signature: Click or tap here to enter text.

Relationship to client: Click or tap here to enter text.

Client Name: Click or tap here to enter text.

## Agency or physician to or from whom information is authorized to be released or obtained:

 Click or tap here to enter text. Click or tap here to enter text.

Name Name

 Click or tap here to enter text. Click or tap here to enter text.

Address Address

 Click or tap here to enter text. Click or tap here to enter text.

Address Address

 Click or tap here to enter text. Click or tap here to enter text.

 Telephone Telephone

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**Consent Form**

# Prior to initiation of evaluations and/or treatment sessions we are required to obtain your consent. In addition, as part of an educational program for undergraduate and graduate students in Communication Sciences and Disorders, we would like to also obtain your permission to observe, videotape, and/or audiotape evaluation and treatment sessions. Below please initial those that you give permission for. Understand that we will protect the confidentiality of your identifying information.

 Initials I consent to evaluation and treatment that falls within the scope of speech­ language pathology practice as defined by the state of New York and the American Speech­Language-Hearing Association. I acknowledge that no guarantee had been made to me regarding evaluation and/or treatment outcomes.

 Initials I understand that with any service, therapy may have some risks. I understand that I have the right to ask about these risks at any point in the treatment process.

 Initials I give my permission for the observation of myself/my child by undergraduate and graduate students along with other department members during evaluation and treatment.

 Initials I give my permission for the initial evaluation to be video/audio recorded to allow the diagnostic team to review and further analyze diagnostic information.

 Initials I give my permission for the video/audio recording of the initial evaluation to be used in Communication Sciences and Disorders courses as case examples.

 Initials I give my permission for therapy sessions to be video/audio recorded so the treating graduate student clinician and supervisor can review current treatment approaches and to help plan future sessions.

 Initials I give my permission for the video/audio recording of therapy sessions to be used in Communication Sciences and Disorders courses as case examples.

 Initials I understand that I have the right to revoke or modify this authorization in writing at any time.

Client’s Name: Click or tap here to enter text.

Signature: Click or tap here to enter text.

Relationship to Client: Click or tap here to enter text.

Date: Click or tap here to enter text.

Rev. 11/2021

FEE **AGREEMENT**

***PLEASE ACKNOWLEDGE THAT YOU HAVE READ EACH OF THE STATEMENTS BELOW BY INITIALING EACH ITEM:***

 Initials I understand that I am financially responsible for all charges whether or not paid by insurance and/or other financially responsible party/ies. I understand that my insurance companies' explanation of benefits is never a guarantee of payment. Should my insurance company fail to pay for services rendered I understand that I am financially responsible.

 Initials I understand that I must notify the office directly with any change in insurance carrier. In addition, l agree to provide updated deductible information regularly. Failure to do so may result in out of pocket payment due to the Winkler Center.

 Initials I understand that the Winkler Center reserves the right to change and/or modify fees with 60 days advance notice.

 Initials I understand that if payment is not made on the date of service, I am responsible for the balance upon receipt of notification.

 Initials I understand that chronically missed appointments, with and without prior notification, could result in dismissal from therapy services.

 Initials I understand that if my check is returned for insufficient funds, I will be charged and additional fee of $25.00

**By signing this document, I agree to all policies and procedures stated above.**

Signature: Click or tap here to enter text.

Name: Click or tap here to enter text.

Relationship to Client: Click or tap here to enter text.

Date: Click or tap here to enter text.

## What is HIPAA?

The Health Insurance Portability and Accountability Act

Provides rights to patients for protection of individually identifiable health information. Permits disclosure of health information needed for patient care and other important purposes. Specifies administrative, physical, and technical safeguards for covered entities and their business associates to use. Ensures confidentiality, integrity, and availability of electronic protected health information. ·

## Our Responsibilities

* We are required by law to maintain the privacy and security of your protected heath information.
* We will let you know promptly if a breach occurs that may have compromised the privacy of security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tel1 us we can in writing. If you tel1 us we can, you may change your mind at any time.

For more information visit: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp/hlml](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp/hlml)

## Your Rights

* Get a copy of your paper or electronic medical record
* Correct your paper or electronic medical record
* Request confidential communication
* Ask us to limit the information we share
* Get a list of those whom we've shared information with
* Choose someone to act for you
* File a complaint if you believe your privacy right have been violated
* Request and received a copy of the fully privacy notice for more information

## Your Choices

* You have the right to tell us to:
	+ Share information with family, dose friends, or others
	+ Share information in a disaster relief situation
	+ Contact you for fundraising efforts

- We never share or sell your information for marketing purposes unless you give us written permission

## Our Uses and Disclosures

- We may share your health information to:

* + Inform other professionals who are treating you
	+ Run our organization and provide better services for you
	+ Bill for your services
	+ Help with public health and safety issues
	+ Do research
	+ Comply with the law
	+ Respond to organ and tissue donation requests
	+ Work with a medical examiner or funeral director
	+ Address workers' compensation, law enforcement, and other government request
	+ Respond to lawsuits and legal actions

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Practices and I have been provided an opportunity to review the document.

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| Client's Name: Click or tap here to enter text. Date of Birth: Click or tap here to enter text. |
| Signature (Client or Parent) Click or tap here to enter text. |
| Print Name: Click or tap here to enter text. Relationship to Client: Click or tap here to enter text. |
| Date: Click or tap here to enter text. |