ARKANSAS STATE UNIVERSITY
SPEECH AND HEARING CENTER
P.O. Box 910 State University, AR 72467-0910
Phone 870-972-3301 Fax 870-972-3788

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of the Notice of Privacy Practices.

____________________________________ ____________________________________
Signature Date

____
Name

____________________________________ ____________________________________
Name of Personal Representative Relationship to Patient

Part 1

Part 2

PATIENT CONSENT FORM

By signing this form, you are granting consent to Arkansas State University Speech and Hearing Center to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Client Name: ______________________________

Signature of
Responsible Party: ___________________________

Date: _____________________________________

PF File#________

SAMPLE-green paper