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

NOTICE OF PRIVACY PRACTICES

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

   Patient Name, File Number, Diagnosis and Treatment at the Arkansas State University Speech and Hearing Center (ASU SHC)

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

   Communication Disorders Faculty, Clinicians, Supervisors, and Student Observers

3. I authorize the following persons (or class of persons) to receive my protected health information:

   Communication Disorders Faculty, Clinicians, Supervisors, and Student Observers

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing addressed to the ASU SHC Director of Clinical Services at P.O. Box 910, State University, AR 72467

6. This authorization expires each academic semester.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from ASU SHC, nor will it affect my eligibility for benefits.

8. My protected health information will be used or disclosed upon request for the following purposes:

   See "Informed Consent" (C4) and "Consent For Release of Information" (C3)

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. 164.524).

10. I understand that ASU SHC will receive compensation for its use and/or disclosure of my protected health information.

*This page **ONLY** may be retained by the client if desired.*