The University of North Carolina at Greensboro
Speech and Hearing Center

Communication Permissions

Preferred Method of Communication

The UNCG Speech and Hearing Center has permission to contact the client via the following methods:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ USPS Mail

Preferred phone number or email address: _____

Can we leave you phone messages? ☐ Yes ☐ No If so, with whom?* _____

*Please add this person to the *Authorization for Disclosure of Protected Health Information* form.

Electronic Mail (E-mail) https://shc.uncg.edu/wp-content/uploads/2024/02/revisedhipaacommform-2-1.pdf

I request that staff members of the Speech and Hearing Center at the University of North Carolina at Greensboro (UNC Greensboro) use e-mail as needed/when applicable to communicate clinical information to me pertaining to health care services that may contain my personal and private medical information. I understand that, although the Provider and UNC Greensboro may attempt to protect the privacy of the contents of email sent to me and will take reasonable measures to protect my privacy, ***the e-mail messages sent to me are not encrypted and travel over the Internet. As a result, there is a risk that the e-mail will be intercepted and read by unauthorized third parties.***

☐ I request the Provider send me e-mail regarding my health care services and assume any risk in doing so. I understand my email is required if I wish to participate in Telepractice (see below).

☐ I do not wish to communicate by email for any reason. I understand that the Provider will not be able to respond to any emails initiated by me.

Email address (print clearly): _____

Telepractice https://shc.uncg.edu/wp-content/uploads/2024/02/Telepractice-Consent-Form-1.pdf

Telepractice requires the practitioner to be licensed in the state that the patient is in at the time the services are delivered. Please confirm your location: ◯ **NC** ◯ **SC** ◯ **VA** Other: _____

I have reviewed the Telepractice Consent Form linked above, understand the policies described in, and agree to abide by them.

☐ **I consent to the UNC Greensboro Speech and Hearing Center delivering telepractice services for me, my child, or any other person for whom I am a legal guardian or authorized signer.**

☐ **I *do not* consent to the UNC Greensboro Speech and Hearing Center delivering telepractice services for me, my child, or any other person for whom I am a legal guardian or authorized signer.**

_____
Client Name (Print or Type Name)

_____ _____
Client/Carepartner/Parent/Guardian Signature Date

_____ _____
Client/Carepartner/Parent/Guardian (Print or Type Name) Date