UNC GREENSBORO
Speech *and* Hearing Center

Communication Permissions

Preferred Method of Communication (specify below)

□ Home Phone _____ □ Cell Phone _____ □ Work Phone _____

□ Email _____ □ USPS Mail (on client information form)

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 UNCG Speech and Hearing Center use e-mail as needed to communicate clinical information pertaining to health care services. Encrypted Messaging (Hushmail) must be used for messages containing protected health information (PHI) such as test results and clinical reports and billing information (e.g., invoices, insurance cards and plan numbers, good faith estimates).

☐ I consent to email (required to participate in Telecare). ☐ I do not consent to email.

Request for Alternative Communication

I understand that I have the option to authorize UNCG Speech and Hearing Center to use non-secure email to transmit the following types of personal information:

☐ Information related to the scheduling of meetings or other appointments including links to Telecare appointments.

☐ General information related to billing and payment

Because e-mail messages that are not encrypted travel over the Internet, I understand there is a risk that the e-mail will be intercepted and read by unauthorized third parties.

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 (**circle one**): **NC SC VA** Other: _____

I have reviewed the Telepractice Consent Form, 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.

_____
Client Name (Print or Type Name)

_____ _____
Client/Carepartner/Parent/Guardian Signature Date

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

Revised 2/7/26