Augmentative-Alternative Communication
Adult Intake Form

To Whom It May Concern:

Thank you for your interest in the University of Central Florida Communication Disorders Clinic and FAAST Demonstration Center.

Enclosed is an Augmentative-Alternative Communication (AAC) intake form for you to complete and return to our office as soon as possible. Please include any additional records you have regarding previous evaluations, services and/or reports. If you have had a stroke or brain injury, please include the written radiologic report.

Upon receipt of your completed intake form, your name will be placed on a waitlist and then we will contact you to schedule your initial session. If you have any questions, please contact us.

Sincerely,

Pamela Resnick, M.A., CCC-SLP
Clinical Educator
Assistive Technology Specialist
UCF Communication Disorders Clinic
Phone: (407) 882-0463

Nancy Harrington, M.A., CCC-SLP
Clinical Educator
Assistant Regional Coordinator
FAAST Atlantic Regional Demonstration Center
Phone: (407) 882-0465
FAAST Atlantic Region
UCF Communication Disorders Clinic
Augmentative-Alternative Communication
Adult Intake Form

Personal Information:

Name: ___________________________ Date of Birth: __________________

Address: ____________________________ City: ____________________________

Home Phone: ____________________________ State & Zip: ____________________________

Phone preferred to schedule appointments: ____________________________

Occupation: ____________________________ Business Phone: ____________________________

Employer: ____________________________

Referred by: ____________________________ Phone: ____________________________

Physician: ____________________________ Phone: ____________________________

Are you a student? _____ Yes _____ No

School Name: ____________________________

Major: ____________________________ Year: ____________________________

Please circle highest level of degree earned.

High School Some College BA/BS Masters Degree Doctoral Degree

Please list Family Members/Caregivers and Contact Information:

Name of person who is completing this form: ____________________________

Email Address: _____________________________________________________

Name/Relationship: ____________________________ Phone: ____________________________

Name/Relationship: ____________________________ Phone: ____________________________

Name/Relationship: ____________________________ Phone: ____________________________
Special Needs:

Do you require the assistance of a caregiver? *(The Clinic requires persons in need of assistance in transferring to have their caregiver on premises at all times.)*
Name/Agency: ______________________  Phone: ______________________

Who provides your transportation to the clinic?
Name/Agency: ______________________  Phone: ______________________

If in need of a wheelchair, can you transfer independently and use the restroom with minimal assistance?

Medical History:

Have you ever had any serious physical illness?  Yes  No  If yes, explain:

Do you have any physical condition or disability?  Yes  No  If yes, explain:

Have you ever had any operations?  Yes  No  If yes, explain:

Have you ever been hospitalized for other reasons? Yes  No  If yes, explain:

Have you experienced any chronic illness?  Yes  No  If yes, explain:

Is your vision normal?  Yes  No  If not, explain:

Is your hearing normal?  Yes  No  If not, explain:

Do you have any medical condition?  Yes  No  If not, explain:

What medications do you take? __________________________________________

Language(s) spoken in your home as a child ______________________________

Language(s) presently spoken at home ______________________________

What is your first language? ______________________________
Do you use:
Alcohol of any kind? No Sometimes Often Daily Amount: __________
Smoke? No Sometimes Often Daily Amount: __________
Drugs? No Sometimes Often Daily Type: __________

Check those conditions with which you have been diagnosed:

____ High Blood Pressure
____ Heart Attack
____ Stroke
____ Neurological Disorders (i.e., Parkinson's)
____ Brain Injury/Anoxia
____ Seizure disorder (i.e., epilepsy)
____ Respiratory Problems
____ Pneumonia
____ Swallowing Disorder (i.e., Dysphagia)
____ Vocal nodules/polyps
____ Vocal cord paralysis
____ Visual difficulties
____ Paralysis
____ Psychological Trauma or Mental illness
____ Learning disability (i.e., dyslexia)
____ Developmental disability (i.e., Autism)

Please check those symptoms that describe your condition:

____ Articulation difficulties (unintelligible speech)
____ Difficulty understanding what people say
____ Difficulty thinking of words
____ Difficulty saying words and sentences
____ Difficulty reading or writing
____ Stuttering (repetitions, prolongations)
____ Confused or difficulty thinking things through clearly
____ Memory difficulty
____ Slow or slurred speech
____ Voice (i.e., Hoarse voice, breathy voice)
____ Difficulty swallowing/ choking or coughing on foods or liquids
____ Need of assistance in walking
____ Hearing difficulty

Speech & Language Information:

Please check the areas that you are concerned with regarding your speech/language:

____ Fluency (Stuttering)
____ Aural Rehabilitation
____ Auditory Processing
____ Speech/Articulation
___ Language
___ Voice/LSVT
___ Reading
___ Swallowing
___ Aphasia – difficulty saying or thinking of words/difficulty understanding words
___ Dysarthria – slurred or unclear speech
___ Accent Reduction
___ Augmentative and Alternative Communications (AAC)
___ TBI – Cognitive or thinking problems

What brings you to our clinic/center? Please list any specific questions you might have
and/or how you think we may be able to help in working with your family:

___________________________________________________________________________

Description of Problem:
___________________________________________________________________________

When was the problem first evident, and who mentioned it?
___________________________________________________________________________

Has this problem interfered with your academic or professional career?
___________________________________________________________________________

Has your speech been better or worse at any time in the past or has it always been about
the same? Describe any changes that have occurred.
___________________________________________________________________________

Have you had prior professional speech, language, reading, and/or hearing testing?
___ Yes  ___ No

If yes, When ____________________ Where _______________________

By whom (Name/Agency): _____________________________________________

Outcome ___________________________________________________________

How would others describe your speech?
___ easy to understand
___ difficult for parents/friends/teachers/co-workers to understand
___ difficult for others (strangers) to understand
___ almost never understood by others
___ different from other people of the same age
Do you have difficulty producing certain sounds? _____ Yes _____ No
If "yes," which ones?

Do you hesitate and/or repeat sounds or words? _____ Yes _____ No
Do you "get stuck" when attempting to say a word? _____ Yes _____ No
Do you have concerns about your voice? _____ Yes _____ No
Do you have concerns about your reading or writing? _____ Yes _____ No

**MOTOR ABILITIES** (Check here if this section not applicable ________)

If applicable, please check all that apply:

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Able but slow</th>
<th>Unable without assistance</th>
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</thead>
<tbody>
<tr>
<td>Holding head steady</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting without help</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Using hands</td>
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</table>

Can most easily control movement of:

_____ Eyes
_____ Head
_____ Foot
_____ Right hand
_____ Left hand
Does client fall or lose balance easily?

In what position does client spend the majority of the time at home? (Please circle one):
Sitting erect, semi-reclined on back, on stomach, on side (Right) (Left)

Apparatus/aids: Please check boxes in this table that apply

<table>
<thead>
<tr>
<th></th>
<th>Uses presently</th>
<th>Used in the past</th>
<th>Never used</th>
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</thead>
<tbody>
<tr>
<td>Wheelchair</td>
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<tr>
<td>Lower extremity braces</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Back brace/trunk support</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Crutches/cane/walker</td>
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<tr>
<td>Splint(s) where?</td>
<td></td>
<td></td>
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<tr>
<td>Overhead sling</td>
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<td>Headstick</td>
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<td></td>
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<tr>
<td>Computer</td>
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<td>Dressing aids</td>
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<td>Transfer aids</td>
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<td>Feeding aids</td>
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<tr>
<td>Other</td>
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</table>

If wheelchair is used, please describe the following:

Make ____________________________________________________________________________

Motorized ______________________________________________________________________

Manual __________________________________________________________________________

Insert components __________________________________________________________________

Lap belt __________________________________________________________________________

Harness __________________________________________________________________________

Lap tray measurements __________________________________________________________________

Independent mobility __________________________________________________________________

Activities tray is used for __________________________________________________________________

Does client prefer the right or left hand? __________________________________________________________________

Most reliable movement patterns:

Pointing __________________________________________________________________________

Eye pointing ______________________________________________________________________

Raising arm ______________________________________________________________________

Other e.g. foot or knee etc. __________________________________________________________________

Does client have difficulty chewing or swallowing? __________________________________________________________________

Does he/she drool? __________________________________________________________________
AIDED COMMUNICATION (Use of communication boards, electronic devices etc.)

Please describe the type of aided communication system/device currently used:

How long has the client been using the device described? ______________________

Please list all communication systems used in the past and check whether the system proved to be unsuccessful or unsuccessful.

<table>
<thead>
<tr>
<th>System</th>
<th>Successful</th>
<th>Unsuccessful (State possible reason for lack of success.)</th>
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How are (or would) vocabulary items represented on the client's communication board/device? Also what size and how many items?

- Photographs ___________ Size ___________ Number ___________
- Color pictures ___________ Size ___________ Number ___________
- Line drawings ___________ Size ___________ Number ___________
- Letters/words ___________ Size ___________ Number ___________
- Other ___________ Size ___________ Number ___________

If possible, list the vocabulary items displayed on the client's communication aid.

The client primarily uses the communication aids/devices:

Imitatively ______________________

In response to questions ______________________

In response to commands ______________________ (Example: "Show me what you want."")

Spontaneously ______________________ (i.e. on his/her own initiative without cueing)

Are modifications necessary to accommodate visual impairments? (i.e. color contrast, placement of pictures on overlays, etc.)

Does the client combine symbols to form a message? How many?

Identify switch, activation site, and reliability of site (if applicable):
SOCIAL INFORMATION/ COMMUNICATION NEEDS

Describe the client’s interactions with others:

Please list the items/activates the client most frequently desires/Attempts communication:

Food:

Daily needs:

Other:

Is the client currently employed? Yes? _____ No? _____

If so, please describe duties and communication needs in the work place.

THERAPEUTIC HISTORY

List all therapeutic/services the client is currently receiving in the table below:

<table>
<thead>
<tr>
<th>Type of Service (ST, OT, PT etc.)</th>
<th>Frequency (# month)</th>
<th>Duration (# minutes per session)</th>
<th>Site (Clinic, outpatient etc.)</th>
<th>Objectives</th>
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If an AAC system is recommended, who will be the people to implement the AAC system for/with the client?

SUPPORT SERVICES

Indicate agencies for possible financial assistance:

Medicaid ___________ Vocational Rehabilitation

Medicare ___________ Private Insurance (company)

SSI ___________ Church group

Service Group ___________ Fund raisers

Other (explain) ___________
**Section I: Patient Information**

Name: ____________________________  Prefer to be called: ____________________________

Address: ____________________________  City: ________  State: ________  Zip: ________

Phone (____) ________  Work Phone (____) ________  Cell Phone (____) ________

The best time to contact me is: ________  A.M.  ________  P.M.  on my  ________  Home phone  ________  Work phone  ________  Cell phone

Date of Birth: _________  Last 4 digits of SSN#: _________

Check Appropriate Box:  ☐ Minor  ☐ Single  ☐ Married  ☐ Widowed

If Student, Name of School: ____________________________  City/State: ____________________________  ☐ FT  ☐ PT

Spouse or Parent’s Name: ____________________________  Employer: ____________________________  Work Phone: ________

Whom may we thank for referring you? ___________________________________________  Phone: ____________________________

Referring Physician: ____________________________  Address: ____________________________

Phone: ____________________________  Fax: ____________________________

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**Section II: Responsible Party**

Relationship to Patient:  ☐ Self  ☐ Spouse  ☐ Parent  ☐ Other: ____________________________

Name: ____________________________

Address (if different from above): ____________________________

City: ____________________________  State: ________  Zip: ________  Phone: (____) ________

Employer: ____________________________  Work Phone (____) ________  Last 4 digits of SSN#: ________

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**Section III: Insurance Information**

Name of Insured: ____________________________  DOB: ________  Relationship to Patient: ____________________________

Last 4 digits of SSN#: ________  Name of Employer: ____________________________  Work Phone: (____) ________

Address of Employer: ____________________________  City: ________  State: ________  Zip: ________

Insurance Company: ____________________________  Grp #: ____________________________  ID#: ____________________________

Ins. Co. Address: ____________________________  Ins. Co. Phone: ____________________________

***DO YOU HAVE ANY ADDITIONAL INSURANCE?  ☐ Yes  ☐ No  IF YES, COMPLETE THE SECTION BELOW***

Name of Insured: ____________________________  DOB: ________  Relationship to Patient: ____________________________

Last 4 digits of SSN#: ________  Name of Employer: ____________________________  Work Phone: (____) ________

Address of Employer: ____________________________  City: ________  State: ________  Zip: ________

Insurance Company: ____________________________  Grp #: ____________________________  ID#: ____________________________

Ins. Co. Address: ____________________________  Ins. Co. Phone: ____________________________
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE

This notice describes our Communication Disorders Clinic's practices and that of:

- Any health care professional authorized to enter information into your Clinic chart.
- All departments of the Communication Disorders Clinic.
- All employees, staff and other Clinic personnel
- In addition, Business Associates of the Communication Disorders Clinic may share medical information with each other for treatment, payment or Clinic operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Communication Disorders Clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Communication Disorders Clinic, whether made by Communication Disorders Clinic personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment
We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians or other Communication Disorders Clinic personnel who are involved in taking care of you at the Communication Disorders Clinic. Different departments of the Communication Disorders Clinic also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Communication Disorders Clinic who may be involved in your medical care after you leave the Communication Disorders Clinic in the case of referrals or hospital transfers.

Notice of Privacy Practices Detailed 1/2011
For Payment
We may use and disclose medical information about you so that the treatment and services you receive at the Communication Disorders Clinic may be billed to and payment may be collected from you, an insurance company or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations
We may use and disclose medical information about you for Communication Disorders Clinic operations. These uses and disclosures are necessary to run the Communication Disorders Clinic and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Communication Disorders Clinic patients to decide what additional services we should offer, what services are not needed and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians and other Communication Disorders Clinic personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Communication Disorders Clinics to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medial information so others may use it without learning who the specific patients are.

Appointment Reminders
We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment at the Communication Disorders Clinic.

Treatment Alternatives
We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services
We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care
We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

As Required By Law
We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety
We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Public Health Risks
We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
**Health Oversight Activities**
We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, inspections and licensure.

**Lawsuits and Disputes**
If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information released.

**Law Enforcement**
We may release medical information if asked to do so by a law enforcement official:
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person’s agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Student Health Center; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**
You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy**
You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request, in writing, to the Communication Disorders Clinic Medical Records department.

**Right to Amend**
If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Communication Disorders Clinic. To request an amendment, your request must be made, in writing, and submitted to the Communication Disorders Clinic Privacy Compliance Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by Communication Disorders Clinic;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

**Right to an Accounting of Disclosures**
You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to the Communication Disorders Clinic Privacy Compliance Officer. Your request must state a time period, which may not be longer than six years and may not include dates before April 1, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically).
Right to Request Restrictions
You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing, to the Communication Disorders Clinic Privacy Compliance Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request, in writing, to the Communication Disorders Clinic Privacy Compliance Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.shs.ucf.edu. To obtain a paper copy of this notice, go to the Communication Disorders Clinic at 3280 Progress Drive, Orlando, FL 32826.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the Communication Disorders Clinic. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the Communication Disorders Clinic. To file a complaint with the Communication Disorders Clinic, contact Dr. Charlotte Harvey, Privacy Compliance Officer, Communication Disorders Clinic, 3280 Progress Drive, Orlando, FL 32826. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.
AUTHORIZATION TO VIDEO TAPE, AUDIO TAPE, PHOTOGRAPH AND/OR OBSERVE

The University of Central Florida’s Communication Disorders Program, in addition to providing services to the Central Florida community, functions as a training clinic for graduate students in the Communication Disorders Program. The Florida Alliance for Assistive Services and Technology (FAAST) also provides similar training and supervision in conjunction with the University Communication Disorders program. Because of this, you may encounter certain situations in the clinic that you might not be exposed to in another treatment setting.

In order for the student clinician to receive thorough supervision, it may be necessary for the clinician to tape (Audiotape and Videotape) the sessions. In addition, there is a one-way mirror in each therapy room, and an observation room adjoining. From time to time, the student clinician’s session may be observed by the supervisor or by other student clinicians. At times, video and audio tape(s) may be used for educational purposes.

A fully qualified professional supervises each client’s program at the Clinic. Graduate Students may be assigned to work with certain clients. A qualified faculty member, however, will be responsible for the professional services. This professional will supervise, counsel and direct the clinical activities.

In hereby authorize clinical personnel from the [ ] Communication Disorders Clinic and/or [ ] FAAST to video tape, audio tape, photograph, and/or observe clinical sessions for:

____________________________
(Client’s name)

____________________________
Date

____________________________
Signature of Client

____________________________
Signature of Parent/Guardian
PERMISSION TO RELEASE INFORMATION

I hereby grant the Communication Disorders Clinic of the University of Central Florida permission to release information from the records of ___________________________ to FAAST and the agencies listed below.  

(Client’s name)

Send to:
FAAST, Florida Alliance for Assistive Services and Technology
325 John Knox Road, Building 400, Suite 402 · Tallahassee, Florida 32303
Soley for the purposes of evaluating the services provided by the FAAST Regional Demonstration Center

(Parent/Guardian initial here)

Send to:
Agency/Business Name: ________________________________________________
Address: ___________________________ City: ___________ State: ______ Zip: __________
Phone: _______________________ Fax: ___________________________

Agency/Business Name: ________________________________________________
Address: ___________________________ City: ___________ State: ______ Zip: __________
Phone: _______________________ Fax: ___________________________

Agency/Business Name: ________________________________________________
Address: ___________________________ City: ___________ State: ______ Zip: __________
Phone: _______________________ Fax: ___________________________

Agency/Business Name: ________________________________________________
Address: ___________________________ City: ___________ State: ______ Zip: __________
Phone: _______________________ Fax: ___________________________

__________________________________________
Date

__________________________________________
Signature of Client

__________________________________________
Signature of Parent/Guardian
PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professional who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will post information of this change. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I authorize UCF Communication Disorders Clinic to use an automated telephone system and/or email and to use my name, address and phone number; the name of my scheduled treating physician; and the time of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare-related communication. I also authorize Communication Disorders Clinic to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voicemail system or answering machine.

Signature of Patient or Personal Representative __________________________ Date __________________________

Printed Name of Patient or Personal Representative __________________________
General Medical Records Request

Please complete the following information:

Patient Name: _______________________________________________________________

Address: _______________________________________________________________

__________________________________________________________________________

Phone: _______________________________________________________________

SSN: ____________________________________ Date of Birth: _____/_____/_____

Provider/Entity to Release Records

Practice/Group Name:  _______________________________________________________________

Treating Provider(s): _______________________________________________________________

Address:  _______________________________________________________________

Phone:  ________________________________ Fax: ___________________________

I authorize the custodian of records of the above named provider(s) or other person/entity (specifically described) to disclose/release the following information (check all applicable):

☐ All records (Diagnosis and Treatment)  ☐ Abstract/Summary (Diagnosis and Treatment)
☐ Laboratory/pathology records  ☐ Pharmacy/prescription records
☐ X-ray/radiology records  ☐ Other (describe specifically)

These records are for services provided on the following date(s): _____________________________________________

Please send the records listed above to:

UCF Communication Disorders Clinic (Attn: Medical Records)
3280 Progress Drive, Suite 500, Orlando, FL 32820
407-882-0468    Fax: 407-882-0483

This authorization shall expire no later than: ___/___/___ or upon the following event ________________________ (whichever is sooner) and may not be valid for greater than one year from the date of signature for Florida medical records. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

___________________________________ ___________________________ _________ _______
Signature of patient or personal representative Printed name Date

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison, 3280 Progress Drive, Orlando, FL 32826.
UCF COMMUNICATION DISORDERS CLINIC
DRIVING DIRECTIONS

The University of Central Florida’s Communication Disorders Clinic is located in the Central Florida Research Park in the Innovative Center at 3280 Progress Drive, Orlando, FL 32826.

From Winter Park
Take University Boulevard east to Alafaya Trail, then right (south) to Research Parkway. Turn left (east) at Bank of America, entering Central Florida Research Park. Turn left onto Progress Drive, you will see a Tropical Smoothie sign on the corner. If you pass through the light at Technology Parkway you will have gone too far. The Innovative Center will be on the left side, just at the entry to the round-about.

From Orlando – Using SR 50
Take Colonial Drive (State Road 50) east to Alafaya Trail. Turn left (north) onto Alafaya Trail. At the third traffic light (Bank of America’s on the corner), turn right (east) on Research Parkway, entering Central Florida Research Park. Turn left onto Progress Drive, you will see a Tropical Smoothie sign on the corner. If you pass through the light at Technology Parkway you will have gone too far. The Innovative Center will be on the left side, just at the entry to the round-about.

From Orlando – Using East-West Expressway
Take the East-West Expressway east. Do not exit to the left where there is a sign indicating that you should go left to UCF but continue on the expressway until you reach the Alafaya Trail exit. After exiting, turn left (north) on Alafaya Trail. After crossing Colonial Drive (State Road 50), proceed to the third traffic light (Bank of America’s on the corner), turn right (east) on Research Parkway, entering Central Florida Research Park. Turn left onto Progress Drive, you will see a Tropical Smoothie sign on the corner. If you pass through the light at Technology Parkway you will have gone too far. The Innovative Center will be on the left side, just at the entry to the round-about.

From North of Orlando
Take the toll road SR-417 South to University Boulevard East (exit 37) towards UCF. Turn right onto SR-434S (Alafaya Trail) in approximately 2.7 miles. From SR-434S you will turn left onto Research Parkway in approximately 0.7 miles, there will be a Bank of America on the corner. Turn left onto Progress Drive, you will see a Tropical Smoothie sign on the corner. If you pass through the light at Technology Parkway you will have gone too far. The Innovative Center will be on the left side, just at the entry to the round-about.

From South of Orlando
Take the Florida Turnpike North or I-4 east to toll road SR-417 North (towards Orlando/Sanford). Merge onto toll road SR-408 East (exit 33a, towards Titusville). Take the Alafaya Trail exit (number 21). After crossing Colonial Drive (State Road 50), proceed to the third traffic light (Bank of America’s on the corner), turn right (east) on Research Parkway, entering Central Florida Research Park. Turn left onto Progress Drive, you will see a Tropical Smoothie sign on the corner. If you pass through the light at Technology Parkway you will have gone too far. The Innovative Center will be on the left side, just at the entry to the round-about.

If you would prefer to use Map Quest for directions, our address is:
3280 Progress Drive, Suite 500, Orlando, FL 32826
Phone: 407-882-0468