APPALACHIAN STATE UNIVERSITY
COMMUNICATION DISORDERS CLINIC

REQUEST FOR RESTRICTED USE OR ALTERNATIVE COMMUNICATION

Name:
Address:
Date of Birth:
Phone:

Information to be restricted:

Nature of restriction:

Information to be communicated confidentially:

Alternative Location/Address/Phone/Email:

To our clients: You have the right to request that we restrict our use and disclosure of your records and information. We do not have to agree to your requested restrictions. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you 1) specify the alternative location, address, or phone number or the alternative means of contact; and 2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that you understand and agree to the above information.

_____ _____

Client, Parent, or Legal Guardian Date