UCF | **Communication Disorders Clinic**

Augmentative-Alternative Communication
Pediatric Intake Form

Client Information	
Name:	Date of birth:
Medical Record Number:	New to FAAST/UCF Communication Disorders Clinic? ☐ Yes ☐ No
Today's date:	Name of person completing this form:
Who referred you to our program? _____	_____ Relationship to patient:

Parent/Guardian Information	
Name(s):	
Address: Street: _____ City, State: _____ Zip Code: _____-_____	Patient's address: (If different from parent/guardian) Street: _____ City, State: _____ Zip Code: _____-_____
Telephone Number(s): Home: _____ Work/cell: _____	
Email address:	Language(s) spoken at home: Need an interpreter? Yes/No

Purpose of Visit
What brings you to our clinic/center? Please list any specific questions you may have. _____
Are you interested in looking at a specific augmentative communication strategy (e.g., device, technique, symbols, etc.)?

Patient Name: _____

Medical Information	
Developmental Diagnoses (e.g., autism, global developmental delay, etc.):	**Medical Diagnoses:**
Medications: (please list name and purpose) *Example: Depakote for seizures*	
Hearing: Has your child's hearing been tested? Yes/No When: _____ Where: _____ Results: _____ Does your child wear hearing aids, use an FM system or have a cochlear implant? Yes/No	**Vision:** Has your child's vision been tested? Yes/No When: _____ Where: _____ Results: _____ Does your child wear glasses? Yes/No
Seizures? Yes/No If yes, please specify type and frequency:	Does your child experience difficulty **sleeping**? Yes/No If yes, please describe:
Feeding/Swallowing: Does your child exhibit problems with feeding/swallowing? Yes/No If yes, please specify: ☐ Dysphagia ☐ Selective ("picky") eater ☐ Drooling ☐ Other (please specify): _____ _____	_____ _____ _____ _____

Educational Setting		
Name and description:		
Address:		Phone Number:
Student/Teacher Ratio:		Grade (if appropriate):
Special Services: (fill in all that apply)		
Type of Therapy	*School, therapist's name, (# sessions x minutes/week)*	*Private, agency name, therapist's name (# sessions x minutes/week) Current Skills (expressive lang., etc)*
Example	*Mary Smith 2x30 minutes/week*	*Anywhere Rehab, Bob Jones 1x60 minutes/week*
Speech Therapy		
Occupational Therapy		
Physical Therapy		
Special Education		
ABA		
Other:		

Behavior	
Describe typical behavior:	List preferred toys, foods, songs, videos, etc.
How long will your child pay attention to an activity he/she is interested in?	Describe your child's personality (e.g., easygoing, rigid, happy, etc.)
Is your child able to easily transition between activities and environments? ☐ Yes ☐ No	Is your child motivated to interact with peers? ☐ Yes ☐ No
Please comment on your child's pretend play skills (e.g., combing doll's hair, pushing train on tracks, etc.): _____ _____ _____ _____	Does your child exhibit aggressive/self-injurious behaviors? ☐ Yes ☐ No If yes, please describe: _____ If Yes, is he/she currently receiving behavioral intervention? ☐ Yes ☐ No If yes, please describe: _____

Communication

Does your child currently: (Check all that apply)

- ☐ Understand simple directions? Example: _____
- ☐ Understand names for people and objects?
- ☐ Understand names for body parts?
- ☐ Answer simple questions? Example: _____
- ☐ Understand prepositions (in, under, on)?
- ☐ Understand color and size words?

Which of the following describe(s) how your child communicates? (Check all that apply)

- ☐ Pointing, gesturing, vocalizing
- ☐ Eye contact, facial expressions
- ☐ Babbling
- ☐ Pulls person to desired object
- ☐ Objects/tangible symbols
- ☐ Pictures
- ☐ Communication boards/book
- ☐ Sign language
- ☐ Single words
- ☐ Two word phrases
- ☐ Three to four word sentences
- ☐ Sentences with some errors
- ☐ Grammatically correct sentences
- ☐ Writing
- ☐ Communication device(s) – If yes, please complete page 6
- ☐ Other (please specify): _____

Please provide examples of your child's communicative messages (e.g., vocalizations, signs, picture symbol use, etc.):

If your child uses communication boards/books/devices to communicate, please provide additional information regarding:

Symbol type:

- ☐ Text
- ☐ PECS(Picture Exchange Communication System)
- ☐ Mayer-Johnson PCS
- ☐ Photographs
- ☐ Other

Number of symbols per page/display: _____

Presentation:

- ☐ Removable icons
- ☐ Static grid

Access:

- ☐ Point
- ☐ Symbol exchange
- ☐ Other: _____

If possible list the vocabulary items displayed on clients communication aid:

Does your child communicate to: (Check all that apply)

- ☐ Ask for wants/needs?
- ☐ Get your attention?
- ☐ Label people, things, or pictures around him/her?
- ☐ Ask questions?
- ☐ Greet people?
- ☐ Ask for help?
- ☐ Share information?
- ☐ Other (Please Describe)

What does your child do when not understood? Please explain (e.g., repeats message, modifies message, stops trying to communicate, etc.):

If your child speaks, do you have difficulty understanding his/her speech? If yes, please explain:

Do others have difficulties understanding his/her speech?

**Please mail copies of previous communication evaluations in advance of scheduled appointment

Communication Device(s):
Please complete if your child is using/has used a communication device

History of speech generating device use:

Name of device:

_____

Age of device: _____

Is the device currently being used? Yes/No

If no, please explain why:

_____

_____

_____

Parent knowledge of device:

- ☐ New device, no experience
- ☐ Basic skills (on/off, navigation)
- ☐ Can program
- ☐ Can operate
- ☐ Can customize
- ☐ Advanced programming

Environments where device is used: (Check all that apply)

- ☐ Structured school activities
- ☐ In therapy
- ☐ In the community
- ☐ At home during structured tasks
- ☐ Spontaneously at home for social interaction
- ☐ Spontaneously at school
- ☐ Spontaneously in the community

Device use: (Check all that apply)

- ☐ Initiates communication with system
- ☐ Uses system to ask and answer questions
- ☐ Needs direction/prompting
- ☐ Single key is used to express a full message
- ☐ Able to participate in a conversation using the device
- ☐ Functional spelling skills
- ☐ Uses system as a backup to speech
- ☐ Makes wants/needs known with device
- ☐ Uses device socially (e.g., greetings, questions, comments, etc.)
- ☐ Navigates device with assistance
- ☐ Navigates independently
- ☐ Explores device but doesn't use functionally

IEP Goals for device use:

Access: (Check all that apply)

- ☐ Direct selection (touchscreen, keyboard)
- ☐ Keyguard (yes/no)
- ☐ Scanning
  - o Type of switch: _____
  - o Number of switches: _____
  - o Type of scanning: _____
- ☐ Joystick
- ☐ Headmouse
- ☐ Eyegaze
- ☐ Other: _____

Physical Status:	
Gross motor status: ☐ Walks independently with no balance or safety concerns ☐ Walks independently but needs supervision for safety ☐ Walks independently using assistive device (i.e. crutches, walker, cane) ☐ Can walk for short distances with physical assistance of another person ☐ Unable to walk	**Fine motor status:** ☐ Has no problem using both hands for feeding, writing, and other fine motor tasks ☐ Has functional use of right hand only ☐ Has functional use of left hand only ☐ Has great difficulty functionally using hands ☐ Can write for short periods of time after which it becomes fatiguing and effortful ☐ Can isolate a finger or thumb to activate a 1" target
Positioning supports: (Check all that apply) ☐ AFOs ☐ Trunk support: o Soft spinal orthosis o Benik trunk support o Leckey waistcoat o Other: _____ ☐ Wrist supports ☐ N/A	**Positioning/assisted transportation:** ☐ Uses a stroller which is pushed by someone else ☐ Uses a manual wheelchair which is pushed by someone else ☐ Drives a power wheelchair using a joystick, head switch array, chin controller ☐ Stander ☐ Walker or gait trainer ☐ Other specialized positioning equipment
Can most easily control movements of: ☐ Eyes ☐ Right hand ☐ Head ☐ Left hand ☐ Foot	

Computer:	
School: Platform: (circle one) Windows/Mac Operating System: Windows 2000, XP, Vista, OSX	*Home:* Platform: (circle one) Windows/Mac Operating System: Windows 2000, XP, Vista, OSX
Does your child use a computer at school? Yes/No	Do you have a working computer your child uses at home? Yes/No
How frequently does your child use the computer at school?	How frequently does your child use the computer at home?
Purpose(s) of computer use: (Check all that apply) ☐ Educational tool ☐ Reward ☐ Communication (e.g., computer-based voice output device, specialized software)	Purpose(s) of computer use: (Check all that apply) ☐ Educational tool ☐ Reward ☐ Communication (e.g., computer-based voice output device, specialized software)
Please list your child's preferred software programs:	
How does your child access the computer? (Check all that apply) ☐ Mouse ☐ Keyboard ☐ Adaptive access (e.g., IntelliKeys, touch window, etc.) ☐ My child does not independently access the computer	

Financial/Insurance Information

Primary Insurance Information:

Health Insurance Provider:	Policy Holder's Name:
Policy Number(s) for Patient:	Group Number:
	HMO or PPO (circle one if applicable)
Primary Care Physician Name:	Phone Number:
Street Address:	City, State:
Zip Code:	

Secondary Insurance Information (if applicable):

Health Insurance Provider:	**Policy Holder's Name:**
Policy Number(s) for Patient:	**Group Number:**

UCF | Communication Disorders Clinic

Section I: Patient Information **Date_____**

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? _____

Person to contact in case of emergency_____ Phone_____

Referring Physician:_____ Address: _____

Phone: _____ Fax: _____

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#_____

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 ADDIONAL 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: _____

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

UCF | Communication Disorders Clinic

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

UCF | Communication Disorders Clinic

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
Solely 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

UCF | Communication Disorders Clinic

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 or disclose to UCF Foundation for purposes of fundraising for the benefit of UCF Communication Disorders Clinic the following: my name, address, phone number, date of birth, gender, the outcome of care, health insurance status and the service dates. I understand when I receive such fundraising communication, I have a right to opt-out of receiving future fundraising communications.

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

UCF | Communication Disorders Clinic

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)
☐ Laboratory/pathology records
☐ X-ray/radiology records
☐ Abstract/Summary (Diagnosis and Treatment)
☐ Pharmacy/prescription 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 Dr, Suite 500, Orlando, FL 32826
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 Dr, Suite 500 Orlando, FL 32826.

UCF | Communication Disorders Clinic

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.

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 medical 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.

Fundraising
We may use or disclose your information for fundraising campaigns, programs and events to benefit UCF Communication Disorders Clinic. We may use or disclose your information, such as your name, address, phone number, date of birth, gender, the outcome of your care, health insurance status and the dates you received services at UCF Communication Disorders Clinic, for fundraising efforts. We may contact you about fundraising and you may opt-out of receiving fundraising communications in the future by contacting us at [insert phone number].

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, Suite 500, 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, Suite 500, 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.