

CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF SPEECH, LANGUAGE, AND HEARING SCIENCES
NORMA S. AND RAY R. REES SPEECH, LANGUAGE, AND HEARING CLINIC

TELEPRACTICE SERVICES CONSENT AND RELEASE FORM

I hereby authorize the Speech-Language Pathology Program, California State University, East Bay, to provide speech, language and/or audiology TELEPRACTICE services to:

(Client's Name)

I understand that “telepractice” includes treatment using interactive audio, video, or data communications. I understand that telepractice also involves the communication of my medical information, both orally and visually.

I understand I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to telepractice. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

I understand that there are risks and consequences from telepractice, including, but not limited to, the possibility, despite reasonable efforts on the part of Cal State East Bay that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

I understand that telepractice with minors requires the presence of an adult caregiver at all times.

I have read, understand and agree to the information provided above.

Date: _____

Signature

Legal relationship to Client if signed by another