College of Health Solutions
Arizona State University

ASU SPEECH AND HEARING CLINIC –RESEARCH AUTHORIZATION

By signing below, I _____ (please print name) certify that I have reviewed this document and agree as follows:

Arizona State University is a comprehensive public research university and the ASU Department of Speech and Hearing Science has numerous active research labs that help support our mission of delivering high quality clinical care.

As a patient of the ASU Speech and Hearing Clinic, you are granted the opportunity to participate in a variety of research studies if you choose to participate.

☐ I give permission for ASU Speech and Hearing Clinic to share with ASU Speech and Hearing Science researchers my contact information and any clinical information housed in the ASU Speech and Hearing Clinic medical record system for research purposes.

☐ I do NOT give ASU Speech and Hearing Clinic authorization to release any information to ASU Speech and Hearing Science researchers.

I understand that any authorization to share information granted above will be valid for 1 year and that I can revoke the authorization at any time by notifying ASU Speech and Hearing Clinic.

I understand that ASU Speech and Hearing Clinic may not condition treatment on whether or not I agree to this authorization.

I understand that by granting this authorization, there is a potential that my information may be re-disclosed by the recipient and no longer protected by the federal privacy regulations.

_____
Signature of Patient, Parent if patient is under 18 or Legally Authorized Representative

_____
Relationship of Legally Authorized Representative to Patient

_____
Date of Signature