



Speech Therapy Telepractice and Technology

Graduate Student Training Program
Department of Communication Sciences and Disorders

Informed Consent

Clinical Records

Clinical records are the live telepractice sessions, video/audiotapes of sessions, written reports, and progress/file notes that are produced during the provision of speech-language-hearing evaluation/treatment services to clients.

Equipment

The Department of Communication Sciences and Disorders (CSD) has a full-service speech and hearing center, which will serve as the on-site training center and is fully equipped with computers and Internet access. The equipment used for the telepractice program includes the following: one Dell Precision T3500 workstation and microphone, headset, speakers and accessories which possess high quality audio and video capabilities; one iMac 21.5-inch 2.7G HZ computer system with similar capabilities and one printer. Clients will use computers, tablets, smart phones or other accessible devices in their homes, schools and/or other secure locations.

Delivery of Services

Speech therapy services will be provided at a small cost to remote sites, using existing computers, Internet connections connected to the secure Web-hosted encrypted Cisco WebEx video conferencing system. The Cisco WebEx system employs a Web 2.0 digital interactive approach where the speech-language pathologist manipulates digital speech therapy materials on a computer in one location, while the patient simultaneously manipulates the same materials on a computer in any secure location. Caregivers and/or other approved individuals can watch the sessions in real time on a computer in any secure location.

Taping, Observation

The clinical education, research and client service functions of the Department of Communication Sciences and Disorders telepractice training program are met in the following ways. Speech-language-hearing services to clients are provided by a clinician team, consisting of a graduate student clinician and an ASHA certified, state licensed clinical supervisor. In the course of evaluation and treatment, client sessions may be recorded (video, audio, photo) and observed for clinical education and teaching purposes. These materials are viewed by supervisors and graduate clinicians and may be used as demonstration tapes or clinical/case study data in CSD courses. In addition, client sessions are observed by undergraduate students completing the ASHA pre-clinical requirement for 25 hours of supervised observations.

Confidentiality

The Cisco WebEx system employs proprietary technology to ensure that the content of all telepractice sessions is encoded and optimized for sharing with only approved individuals. All presentations are encrypted using the 128-bit SSL encryption standard to ensure confidentiality of sessions. Visit webex.com for more information regarding security standards of the Cisco WebEx system.

Individual client records are kept in accordance with accepted procedures, and confidentiality is maintained in accordance with both state law and ASHA ethical standards. Information related to client services in the department is kept confidential with the following exceptions: (1) when clients sign a form permitting us to release information about them to specified others, (2) when we use videotapes/audiotapes and/or clinical data from sessions in CSD courses and course assignments, with the client's signed permission on this form.

Except as otherwise specified below, I hereby consent and authorize the Department of Communication Sciences and Disorders, its employees or agents, to release any and all of the information contained in the clinical records and to discuss any information relating to the diagnosis and treatment of _____ to CSD Department clinical supervisors, graduate student clinicians and undergraduate students completing pre-clinical requirements for the purposes of clinical and pre-clinical education and client service functions.

Information that I refuse to disclose (specify): _____

If the clinical records contain any of the following information, I understand that the CSD Department needs my specific consent to disclose such information:

1. I **Do** ____ **Do Not** ____ authorize disclosure of information which refers to treatment or diagnosis of substance abuse.
2. a. I **Do** ____ **Do Not** ____ authorize disclosure of information which refers to treatment or diagnosis of mental health.
2. b. I **Do** ____ **Do Not** ____ want to review this information before it is released. I understand that reviews must be supervised.
3. I **Do** ____ **Do Not** ____ authorize disclosure of information which refers to HIV/AIDS test results, infection status or treatment information.

Duration of consent, right to refuse/revoke authorization

This authorization will expire in 12 months from the date of signature and authorizes repeated disclosures during that time period. Clients have the right to refuse to authorize disclosure of all or part of the information related to their speech-language-hearing services, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim of health benefits or other insurance and/or other adverse consequences. Clients have the right to revoke this authorization at any time by notifying the department with a written revocation before the expiration date subject to the right of any person who acted in reliance on the authorization prior to receiving notice of the revocation. Revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

The undersigned states that she/he is the person whose records are involved, or if not the person, that she/he is the legal guardian of the person, or if the person is a minor, the person's parent or legal guardian and that she/he has full power and authority to issue this release.

I have read and understood the above information regarding the use of clinical records. I understand that I am entitled to a copy of this Client Consent Form. I understand that signing this Client Consent Form is completely voluntary and is not required as a condition to receive services from the CSD Department.

Signature: _____ Relationship to Client: _____ Date: _____

Witness: _____ Date: _____