Speech-Language-Hearing Clinic
CONSENT FOR SERVICES

Services cannot be provided without written permission. We request that you complete this form with your treating clinician to enable explanation and responses to any questions you may have.

Please indicate the consent by checking the following:

___ Evaluation
___ Therapy

Permission is given for therapy sessions to be observed by (check all for which permission is granted)

___ Family
___ CD Students
___ Other Students in Educational Training

Permission is given to the Program Personnel to use items checked below for clinical therapy purposes:

___ Diagnostic Information
___ Therapy Information
___ Photographs
___ Video Recordings
___ Audio Recordings

Permission is given to the Program Personnel to use items checked below for educational purposes*:

___ Diagnostic Information
___ Therapy Information
___ Photographs
___ Video Recordings
___ Audio Recordings

Permission is given to the Program Personnel to use items checked below for research purposes*:

___ Diagnostic Information
___ Therapy Information
___ Photographs
___ Video Recordings
___ Audio Recordings
*Any information used for educational and/or research purposes would not include identifiable information (other than facial recognition with photographs or video recordings).

Please sign below, thank you.

______________________________
Printed Name

______________________________
Signature of Client/Parent/Guardian

______________________________
Today’s Date

______________________________
Relationship to Client

______________________________
Witness

Eastern Kentucky University is an Equal Opportunity/Affirmative Action Employer and Educational Institution.