FOR CALENDAR YEAR: ____

CLIENT NAME: ___________________________

PERMISSION TO OBSERVE AND MAKE AUDIO-VIDEO TAPE

I understand that the Robert L. Milisen Speech, Language and Hearing Clinics at Indiana University are both a teaching and service center. It serves the training needs of students preparing for careers in Speech-Language Pathology and Audiology. It also provides diagnostic and remedial service to persons with speech, language or hearing disorders

I understand that the therapy done by student clinicians requires periodic observation by staff supervisors. I also realize that the use of audio and video tape recordings can be valuable in the professional training of students.

Therefore, I agree to permit observation of my diagnostic and/or therapy sessions by staff supervisors and others in the professional training program of the center. I also am willing to permit audio and/or video taping to be used for educational purposes only. I also understand that all information about me will be kept confidential and that everything will be done to protect my privacy. Finally, I understand that this form should be returned to the Speech, Language and Hearing Clinics before my first appointment if at all possible.

____
Client/Guardian Signature

____
Date

Please call 855-6251 if you have any questions or concerns