INDIANA UNIVERSITY
Robert L. Milisen Speech-Language & Hearing Clinics
Department of Speech and Hearing Sciences
200 S. Jordan Avenue
Bloomington, IN 47405-7002
Phone: (812) 855-6251
Fax: (812) 855-5561

PERMISSION TO EXCHANGE INFORMATION, EVALUATE AND RECORD

Name of student:_____ DOB:_____
Address:_____
_____

EXCHANGE OF INFORMATION

I _____hereby authorize the Robert L. Milisen Speech-Language & Hearing Clinics to exchange information (send and receive information) with the following professionals or agencies.

_____ _____
Professional or Agency Address

Information to be exchanged may include medical records, progress reports, speech-language pathology reports, psychological reports, academic records, IEPs or IFSPs, hearing specialist records, and other information from school personnel such as teachers and aides.

Signed: _____ Date:_____

Relationship to the child:_____

EVALUATION

I, _____ give permission to the Robert L. Milisen Speech-Language Clinic to perform a speech-language evaluation on my child. This may include classroom observations as well as formal and informal assessment activities.

Signed:_____ Date:_____

RECORDING

I, _____ give permission to the Robert L. Milisen Speech-Language Clinic to make audio-recordings of my child's speech-language evaluation and/or therapy sessions for clinician use only.

Signed:_____ Date:_____