Department of Communication Sciences and Disorders
James L. & Dorothy H. Dewar College of Education & Human Services
Speech-Language Hearing Clinic
Address 1500 N. Patterson Street • Valdosta, GA 31698-0104
Phone 229.219-1301 • **Fax** 229-219-1302 **Web** http://www.valdosta.edu/coe/comd
A Regional University of the University System of Georgia & an Equal Opportunity Institution

Consent for Diagnostic/Treatment Services (Part 1)

Client's Name: _____ **Client's DOB:** _____

Parent/Guardian's Name (if client is a minor): _____

I, _____, HEREBY AUTHORIZE Valdosta State University Speech and Hearing Clinic audiologists, speech-language pathologists, or students under the direct supervision of audiologists or speech-language pathologists, to conduct requested services at the Valdosta State University Speech and Hearing Clinic. I understand that any evaluation and treatment will be completed by a licensed and certified audiologist or speech-language pathologist or by a student under direct supervision.

I agree that for training and research purposes, therapy or evaluation sessions may be observed by supervisors, faculty, and student clinicians. **I agree that sessions may be photographed, audio-recorded, videotaped or stored in an electronic format, and recordings of sessions may be used for training, supervision, research, or for educational purposes in professional settings.** I also authorize the use of clinical case discussion and review of records for professional and/or teaching purposes. I agree that all information will be held in the strictest confidence legally possible. I understand my clinician must be in compliance with child abuse reporting laws and court mandated rulings regarding release of confidential information.

- **AUTHORIZATION FOR CONSENT:** I fully understand and accept the terms of this *Consent for Diagnostic and Treatment Services*.

  _____ Date _____
  Signature of Client (representative or parent/guardian if a minor)

  Authority of Representative to Act on Behalf of Client _____

- **AUTHORIZATION FOR DATA COLLECTION:** I agree to allow testing or treatment data to be included in the ongoing pool of clinic research data, understanding that this material will <u>not</u> contain any identifying data, but rather that all data will be coded by consecutive subject number.

  _____ Date _____
  Signature of Client (representative or parent/guardian if a minor)

  Authority of Representative to Act on Behalf of Client _____

- **ACKNOWLEDGEMENT OF PRIVACY NOTICE:** I acknowledge that I have received The Speech and Hearing Clinic *Notice of Health Information Privacy Practices.*

  _____ Date _____
  Signature of Client (representative or parent/guardian if a minor)

  Authority of Representative to Act on Behalf of Client _____

See reverse side for continued consent form

Consent for Food (Part 2)

- **AUTHORIZATION TO DISTRIBUTE FOOD:** I agree to allow Valdosta State University Speech and Hearing Clinic to distribute foods/beverages during therapy and/or diagnostic sessions.
- EXCLUSIONS: (INCLUDE ANY FOODS ALLERGIES,ECT)

  _____

  _____

_____ Date _____

Signature of Client (representative or parent/guardian if a minor)

Authority of Representative to Act on Behalf of Client _____