UNIVERSITY OF KENTUCKY
Chandler Medical Center
Division of Communication Disorders
CTW Building
900 South Limestone
Lexington, KY 40636-0200
Phone: (859) 257-7918

Client: ______________________________ Birth date: ________________

Address: ____

CONSENT FOR SERVICES

Clinical services cannot be provided without written permission. We request that you complete this form and return it to us as soon as possible.

The evaluative, rehabilitative, and consultative services offered to individuals seen in the University Of Kentucky Division Of Communication Disorders Clinic and its affiliated laboratories are part of the supervised student training program. Clients may be observed by students, faculty, and family members. Routine photographs and audio and video tape recordings may be made by Program Personnel and live or recorded viewing by closed circuit television may be employed for educational/research purposes. Special tests and procedures are sometimes utilized to assist in gaining additional information about the client's problem and to further training and research goals. It is understood that these observations and all written and taped records will be treated with respect for privacy and confidentiality.

Please sign this form below indicating that you have read this statement and that you give permission for these observations and records to be made for the purpose stated above.

Signed: ____

Relationship to applicant, if other than applicant:

____

Date: _________________________________

Witness: _______________________________