BOSTON UNIVERSITY

College of Health and Rehabilitation Sciences
Aphasia Community Resource Center

CONSENT FORM

The Speech, Language and Hearing Center at Boston University has as its primary purpose of training students who wish to become speech-language pathologists and audiologists. The BU Speech, Language and Hearing Center respects the right of privacy of its clients and will treat all sessions and information regarding its clients as confidential in accordance with applicable law. Each client who is seen at the BU Speech, Language and Hearing Center is asked to give consent to the observation and audio and/or video recording of sessions involving the client and to the use of these audio and/or video recordings and other information regarding the client for purposes related to the treatment of the client, operations, and education, including use by students in classroom presentations.

Please be advised that students, faculty and staff at the BU Speech, Language and Hearing Center sometime consult with physicians, other professionals, and individuals at agencies, schools, clinics, and other entities for purposes related to the client's treatment. In order to enable the Center and other parties involved with the client's care to consider relevant information, we will share information that we deem appropriate.

I understand that by signing this form, I give my permission for individuals associated with Boston University to:

1. Observe and record sessions either through audio and/or video involving the client.

2. Use of such audio and/or video recordings and other information regarding the client for purposes related to treatment or operations.

3. Use of such audio and/or video recordings and other information regarding the client for purposed related to education, including use in classroom presentations;

4. Share information regarding the client with physicians, other professionals, and individuals at agencies, schools, clinics, and other entities as the Center deems appropriate for purposes of treatment of the client.

Client Name (Print Name)

Signature of Client or Parent/Guardian

Emergency Contact (Print Name)

Phone Number

Date

Send to:
The Boston University Speech, Language and Hearing Center
c/o Speech, Language and Hearing Sciences
635 Commonwealth Avenue, 3rd Floor
Boston, MA 02215