Adult Client
Permission to Audio and/or Video Record

I, ______________________________________, agree to allow audio and/or video recordings of my treatment and/or evaluation sessions to be made during the course of my treatment at the Ludden Speech and Language Clinic. I understand that these recordings will be used only for research and/or educational purposes, such as lectures, workshops and inservices. No identifying information about me (e.g.last name, address or birthdate) will be provided during the presentations.

The recordings will be identified by first name and age only.

Signature of Client ____

Signature of Legal Guardian (If Applicable): _________________________

Date____