



Communicative Sciences & Disorders  
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**AUTHORIZATION FOR VIDEO/AUDIO TAPING, STUDENT OBSERVATIONS, AND  
STUDENT CHART REVIEW FOR EDUCATIONAL PURPOSES**

Client's Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

I understand that the Alabama A&M University Speech-Language-Hearing Clinic is housed in an educational environment. I hereby consent to the video and/or audio taping, students observing, and/or reviewing charts of evaluation and/or therapy sessions of the above-named individual to be used for teaching purposes only.

The following exception(s) is/are required:

\_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_