



NOVA SOUTHEASTERN UNIVERSITY

## AUDIO/VISUAL RECORDING & OBSERVATION FORM

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Client's First Name

\_\_\_\_\_  
Middle Initial

\_\_\_\_\_  
Last Name

\_\_\_\_-\_\_\_\_-\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Client, Parent(s) or Guardian Name(s)

In consideration of the educational function of the Nova Southeastern University Clinics for Audiology and Speech-Language Pathology, I give consent that I (we) and/or my child may be observed for education or research purposes while receiving services at this Clinic. It is understood that the staff, observers, and students will consider any information revealed during such examinations or demonstrations as privileged communications and will hold such information in confidence, except. when authorized by me (us) to release it to appropriate medical, social, educational, health or other agencies.

Also, I consent that audio and video recordings and photographs may be made for client records and/or for use in education, research and media. It is understood that in such cases tapes will not be identified by name.

This form has been fully explained to me (us) and I (we) certify that its contents are understood.

\_\_\_\_\_  
Client, Parent(s) or Guardian(s) Signature

\_\_\_\_\_  
Date



NOVA SOUTHEASTERN UNIVERSITY

**RELEASE OF INFORMATION FROM CASL**

\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
**Client's First Name                      Middle Initial                      Last Name                      Date of Birth**

\_\_\_\_\_  
**Client, Parent(s) or Guardian Name(s)**

I authorize the Nova Southeastern University Clinics for Audiology and Speech-Language Pathology to release information regarding:

\_\_\_\_\_  
**Client's Name**

as indicted by my signature (below). The clinic may release only the information specified below to the designated agencies.

	Information to be released	Name and Address of Agency to Receive Information	Authorized Signature	Date
1	<i>All reports</i>	<i>Parent(s) or legal guardian(s)</i>  <i>Address:</i>	X	
2			X	
3			X	
4			X	



NOVA SOUTHEASTERN UNIVERSITY

**RELEASE OF INFORMATION TO CASL**

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Client's First Name

\_\_\_\_\_  
Middle Initial

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Client, Parent(s) or Guardian Name(s)

This form fully protects your civil liberties when the following conditions are met:

1. Make sure all blanks on the form are filled in before you sign it.
2. Do not sign form as required condition for treatment.
3. Sign this form only after a specific request for information has been made.
4. Make sure the release of information is in your best interest.
5. Make sure you understand that the release of information is limited to the person, agency or insurance company named below and that this information is not to be passed on to anyone else or to be used for any other purpose than the one specified below.
6. Make sure your signature is dated on the line below.

*Any information you authorize other professionals to release to this facility will be held strictly confidential and will not be released without your permission. Authorization is in effect during the time Client's case is active or for one year, whichever period is shorter.*

I authorize \_\_\_\_\_ to release information from  
**Agency or Provision Service**

the personal/clinical file of \_\_\_\_\_ to **Nova Southeastern University**  
**Client's Name** **Clinics for Audiology and Speech-Language Pathology**  
**Westport Building**  
**3301 College Avenue**  
**Fort Lauderdale, FL 33314**  
 **#(954)262-7726 / Fax #(954)262-3940**

\_\_\_\_\_  
Client, Parent(s) or Guardian(s) Signature

\_\_\_\_\_  
Date

**OR**

I decline release of information from any agency or provision service to Nova Southeastern University's Clinics for Audiology and Speech-Language Pathology (CASL).

\_\_\_\_\_  
Client, Parent(s) or Guardian(s) Signature

\_\_\_\_\_  
Date