Indiana University

Speech-Language & Hearing Clinics

Department of Speech Language & Hearing Sciences

PHOTOGRAPHY AND VIDEORECORDING FOR EDUCATIONAL PURPOSES AUTHORIZATION FORM

Client

Client's Full Name: _____

Street Address: _____ Apt No.: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____

❑ I hereby authorize the Indiana University, Speech-Language & Hearing Clinics (SLHC) to photograph, make video recordings of my/my child's therapy sessions.

I authorize the use and disclosure of the audio/or video recording of my/my child's diagnostic and/or therapy sessions which may include health information for each purpose I have checked below. I also understand that these audio/video recordings will contain identifiable information such as voice and full facial images.

❑ Review by clinical supervisor(s) of the Clinics and any student-clinician(s) involved in administering my therapy sessions. These recordings will be used for evaluating the student-clinician, quality of care and educational purposes.

❑ Review and use by all SPHS staff, faculty and students for educational and professional training purposes.

❑ Use outside of the Clinics for educational and professional training purposes. I understand that such purposes may include, but are not limited to, the compilation of recordings to be used within professional training manuals and DVDs, the presentation of recordings as part of lectures, seminars, presentations, or similar professional and/or educational sessions to speech-language pathology and audiology professionals. I understand that such purposes shall not include commercial use.

PURPOSE:

I understand I am authorizing Indiana University, Speech-Language & Hearing Clinics located at 2631 East Discovery Parkway, Bloomington, IN 47408 to use and release the information identified above for the following purpose.

Education or Professional Presentations:

Still photography, audio and video recordings of client therapy sessions provide a valuable tool in the educational and professional training of the student-clinicians, staff and faculty, as well as other students and professionals outside the University, and within the professional fields of speech-language pathology and audiology. These recordings will be used to for educational or professional presentations to teach healthcare clinicians including SLHC staff, faculty and students. These recordings may also be used as part of future educational or professional presentations outside of Indiana University which might include DVDs, Lectures, seminars, or similar professional and/or education sessions to speech-language pathology and audiology professionals.

CONSENT AND RELEASE:

- I hereby agree and consent to the recording and disclosure of my information as described here. I hereby release Indiana University from any liability arising from the taking and using of such Recording.
- I understand Indiana University cannot require me to sign this authorization as a condition for providing treatment.
- I understand I may ask for the recording process to be stopped at any point during the recording session.
- I understand this authorization may be revoked by me at any time by submitting a written request to:

- Dawn Egan
  dawnegan@indiana.edu
  Speech-Language and Hearing Clinics 2631 East
  Discovery Parkway
  Bloomington, IN 47408
  812-855-6251

- I understand my requested revocation applies to future use of recordings, not recordings Indiana University has already used.
- I understand the material released as a result of this authorization may contain identifying information and could be subject to re-disclosure and no longer protected by the laws applying to medical information release.
- I understand this authorization will expire one (1) year from the date I sign unless I exercise my right to revoke prior to the expiration date.

_____

Signature of Patient or Legal Representative

_____

Printed Name of Patient or Legal Representative

_____

Date

**If signed by a legal representative; state the relationship and identify below the authority to act on the individual's behalf.*

***Individual is a Minor and I am:** ☐ Parent ☐ Custodial Parent ☐ Legal Guardian ☐ Other: _____