**Middle Tennessee State University**

**Speech-Language-Hearing Clinic**

**P.O. Box 364**

**Murfreesboro, TN 37132**

**RELEASE OF INFORMATION**

**CLIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BIRTHDATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_ Yes \_\_\_\_\_ No I authorize the MTSU Speech-Language-Hearing Clinic to**

**release and/or secure a report of diagnostic and/or therapy**

**information:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\_\_\_\_\_ Yes \_\_\_\_\_ No The faculty of the MTSU Clinic has my permission to use my**

**clinical data as part of a research project as long as my**

**name will not be used.**

**\_\_\_\_\_ Yes \_\_\_\_\_ No The MTSU Clinic occasionally takes photographs of clinical**

**activities for use in brochures, presentations, and**

**publications. If I appear in a photograph, the Clinic has my**

**permission to use it for professional purposes.**

**\_\_\_\_\_ Yes \_\_\_\_\_ No The MTSU Clinic has cameras in every treatment room and**

**all sessions are recorded for clinical training purposes. I**

**understand these videos are on a secure server in the clinic and may be viewed by faculty, staff, and students in Speech-**

**Language Pathology and Audiology.**

**\_\_\_\_\_ Yes \_\_\_\_\_ No I give permission for the videos to be used outside of clinic**

**(classroom lectures or professional presentations) for**

**training purposes.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Signature of responsible person**