



Consent Form

I understand that my records are protected under state and federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time. I understand that information is limited to staff whose work assignments reasonably require access to my data for the purposes specified as related to the services provided. I give permission for Center for Speech, Language and Learning, Inc. to observe, test, or treat my child for speech therapy and/or occupational therapy purposes. I also give permission for individuals that work with my child at this facility to collaborate and share information related to the above stated purposes.

- I give permission for CSLL, Inc. to bill my insurance company for services rendered.
- I give my permission to video my child solely for the purpose of confidential therapeutic purposes (such as evaluations, social skill group learning or for parent education and review).
- I do not give my permission to video my child for any purposes.
- I give permission for professionals at CSLL, Inc. to contact me via email, understanding that sensitive information and HIPAA regulated information will not be transferred this way, unless I request to do so in writing or in an email.

Parent/ Guardian / Legal Representative Signature

Date

Please list all the parents / step parents that we have permission to speak with regarding any services provided by CSLL, Inc. (If there is a parent or other party that we are not supposed to communicate with please discuss this with the Office Manager.)

Acknowledgement of Receipt of Privacy Policies

I have been informed of and received a copy of Center for Speech, Language and Learning, Inc.'s policies regarding my Protected Health Information as well as email risks and how it will be used. I understand that written consent may be required for some requests.

Print Name

Date

Signature