The Speech, Voice & Language Clinic

www.speechvoice.ca

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AUTHORIZATION FOR CONSENT TO TREATMENT AND RELEASE OF INFORMATION

I _____ authorize the Speech Voice and Language Clinic to proceed with a clinical evaluation with view to treatment. I authorize _____to send a report to my Doctor and/or specialist, and obtain necessary information involved in the assessment, care and treatment of: **(CHOOSE EITHER 1 or 2)**

1. **Me: Name_____ Date of Birth: Day:_____ Month:_____ Year:_____ Age:_____**
2. **and/or my child: Name:_____ Date of Birth: Day:_____ Month:_____ Year:_____ Age: _____**

This is effective while receiving services/treatment, and I understand that I may amend/revoke the same in writing at any time.

My family physician: Name:_____

Street:_____ Suite:_____

City:_____ Postal Code:_____

Telephone: _____Fax:_____

My specialist: Name:_____ Title:_____

Street:_____ Suite:_____

City:_____ Postal Code:_____

Telephone:_____ _____Fax:_____

Other:_____

I hereby consent to assessment, care and treatment of_____ by Speech-Language Pathologist _____.

_____ _____

Signature of Client Signature of Speech-Language Pathologist

_____

or Signature of Authorized Person

_____

Relationship to client

Address:_____

_____

Postal Code: _____

Phone:_____

Date/Client:_____ Date/SLP: _____

PRIVACY POLICY

I give my consent to The Speech, Voice and Language Clinic to collect personal information (e.g. telephone numbers, address, date of birth, gender, family status, health conditions, educational history, social history, etc.) in order to provide professional services.

INITIAL:_____

VIRTUAL THERAPY

Should I wish to engage SVLC in virtual therapy, I recognize that this mode of intervention may not be totally secure in terms of protecting my privacy. I recognize that SVLC will take all reasonable measures to assure my privacy. Nevertheless, I recognized that breeches of my privacy may be possible.

INITIAL:_____

COVID-19

I recognize that by agreeing to engage in services in the premises of SVLC, I may risk being infected by COVID-19 despite SVLC taking all reasonable measures to protect my safety by following the policies and procedures recommended by the Ministry of Health of Ontario and the College of Audiologists and Speech Language Pathologists of Ontario**.**

INITIAL:_____

SIGNATURE Of CLIENT:_____DATE:_____

PRINTED FIRST AND LAST NAME OF AUTHORIZED PERSON/CLIENT:

_____

IF CLIENT IS A MINOR, PRINTED FIRST AND LAST NAME OF CHILD:

_____

SIGNATURE OF SPEECH-LANGUAGE PATHOLOGIST/WITNESS

_____

DATE:_____