



**Communication Sciences
and Disorders**

College of Education

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Communication Disorders Clinic - Confidentiality of Records Form

I understand that information pertaining to my consultation will be treated as confidential, *subject to the following limitations:*

- A. My clinician may discuss relevant features of my clinical session with his or her supervisor, to assist in the treatment process.
- B. Because all records may be subject to legal process and/or applicable law, no assurance as to the confidentiality in those situations is made.

My signature below indicates my acceptance of the above conditions.

I represent that I am eighteen (18) years of age or older.

Name of Client

Signature of Client

Date

If needed, Signature of Parent/Guardian