REDMOND
speech & language

I, _____, (patient/care giver), agree to allowing a speech language pathology student to observe my/my child's sessions from _____ to _____ .

Redmond Speech & Language therapists will be present at all times. Student is required to follow HIPAA guidelines and all information shared will be kept confidential. A copy of our HIPAA statement will be provided upon request.

Patient Name:

DOB:

_____ _____
Signature of Patient/Legal Representative of Patient Date