Department of Speech and Hearing Sciences
Roinn na nEolaíochtaí Urlabhra agus Éisteachta

# Audio Consent Form

I agree that I / my child (delete as appropriate) may be audio recorded for the purpose of educating Speech and Language therapy students.

I understand that the audio recording will be stored safely in the Brookfield clinic in UCC for up to 3 years and only used for the purpose stated above.

I give my permission for the audio recording to be (tick as appropriate):

(a) viewed by the student/s who are currently seeing me / my child ☐

(b) used for training other Speech and Language therapy students ☐

(c) other (please specify) ________________________________________

Signed: ________________________________________

Print Name: ________________________________________

Client's Name: ________________________________________

Relationship to Client: Parent/Carer/Spouse (delete as appropriate)

Date: ________________________________________