CALIFORNIA STATE UNIVERSITY, EAST BAY
DEPARTMENT OF SPEECH, LANGUAGE, AND HEARING SCIENCES
NORMA S. AND RAY R. REES SPEECH, LANGUAGE, AND HEARING CLINIC

CLIENT'S AGREEMENT AND RELEASE FORM

I hereby authorize the Speech-Language Pathology Program, California State University, East Bay, to provide speech, language and/or audiology services to:

____ (Client's Name)

I understand that the services indicated above may be provided by student clinicians as part of their pre-professional and professional clinical training. Such services will be supervised by a certified or licensed Speech Pathologist or Audiologist. I understand, further, that the assignment of student clinicians is at the discretion of the supervisory staff and that services may be interrupted or terminated according to the training requirements of the clinical training program and/or the availability of clinical personnel. I understand that every effort will be made to refer clients for appropriate services when those services ca9T T0 Tc 0 Tw -2525-1.18Td[(U)2 (ni)-2 (ve)4(r)3(s)-1 (i)-2 (t)-2 (y)0 (,)]TJ0.004Tc 0.024Tw

l all costs and expenses incurred in connection
y) resulting from or in any manner arising out of
uage Pathology Program.

risk of exposure to COVID-19. I understand that
of exposure to COVID-19 will exist.

ed to any person or agency without my specific
permitted by applicable law.

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Signature

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nship to Client
ing for dependent child or disabled adult)