Consent Form
Video and/or Audio Recordings
General Educational Purposes

Northern Illinois University offers a variety of undergraduate and graduate programs with a clinical focus. Some of these programs include Speech-Language Pathology, Audiology, Physical Therapy and Rehabilitation Counseling. Students enrolled in these programs are developing the knowledge base and clinical skills necessary to practice independently in these professions. At times, it is beneficial to use video recordings and/or audio recordings of clinical treatment sessions at the Speech-Language Hearing Clinic and/or Physical Therapy Clinic for general educational purposes. In order to use clinical recordings with those not directly involved in patient/client care, it is necessary for you to give us permission to do so.

My signature on this form acknowledges that I give Northern Illinois University, its Department of Allied Health and Communicative Disorders and all respective employees and agents my permission to use the video and/or audio recordings of me and/or my family member’s treatment sessions for general educational purposes. I understand that all, or portions, of the content of the recordings may be used in the classroom to educate students without compensation of any kind. I also understand that my name and/or my family member’s name will not be associated with the audio and/or video recordings.

I, on behalf of my heirs, executors, administrators, employers, agents, representatives, insurers, and attorneys, hereby relinquish all rights and privileges to all video recordings and/or audio recordings while relinquishing all current and future rights and interests for the purpose contemplated herein.

I understand that my authorization will remain in effect until I tell Northern Illinois University in writing, at the address above, that I have decided to cancel my authorization. I can cancel my authorization at any time.

☐ I decline to have recordings of sessions used for general educational purposes.

___________________________________  ______________________________________
Name (Patient/Client)  Name (Legal Representative)

___________________________________  __________________________
Signature  Date

___________________________________  __________________________
NIU Representative  Date