

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 are not available.

I understand that I will be responsible for all costs and expenses incurred in connection with the services provided (including but not limited to transportation, parking, and other expenses) resulting from or in any manner arising out of the Speech-Language Pathology Program.

I understand that there is a risk of exposure to COVID-19. I understand that the risk of exposure to COVID-19 will exist.

I understand that I am not releasing any person or agency without my specific written consent as permitted by applicable law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Client  
(Required for dependent child or disabled adult)