SAN FRANCISCO STATE UNIVERSITY
COMMUNICATIVE DISORDERS CLINIC
BURK HALL 114, 1600 HOLLOWAY AVENUE
SAN FRANCISCO, CA 94132
415/338.1001 (phone) 415/338.0916 (fax)

F-27: STATEMENT OF UNDERSTANDING RE: CLINIC PURPOSES

____
CLIENT NAME

____
ADDRESS

____
CITY **STATE** **ZIP CODE**

____
TELEPHONE

I request evaluation and/or therapy for ______________________________
I understand that therapy/evaluation includes individual testing procedures deemed necessary by the Communicative Disorders Clinic and procedures may be audio/video taped. I also understand that the Clinic at San Francisco State University is a teaching facility, and that the audio/video tapes are to remain confidential and used solely for teaching/learning purposes.

______________ ______________________________
Date Signature Relationship