**CONSENT FOR ASSISTIVE TECHNOLOGY SERVICES**

**Individual’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Individual’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian’s Name (if minor) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Tools for Life at Georgia Institute of Technology, to conduct requested assistive technology evaluation/ consultation. I understand services will be completed by a professional in the assistive technology field.

I agree, for writing evaluation purposes, the assistive technology evaluation/ consultation may be observed by members of the Tools for Life staff and/or contractors with them. I agree that Tools for Life may audio record, videotape, and/or take pictures if needed to assist with coming up with assistive technology solutions. These recordings and picture will only be used in the evaluation process and not for any other purposes. I agree that all information will be held in the strictest confidence legally possible. I understand that Tools for Life must be in compliance with child abuse reporting laws and court mandated rulings regarding the release of confidential information.

**AUTHORIZATION FOR CONSENT:**

I fully understand and accept the terms of this Consent for Assistive Technology Services.

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Individual/ Authorized Representative Signature Relationship (if applicable) Date

**CONSENT TO CORRESPOND ELECTRONICALLY:**

Email does not always provide a secure means of communication. There is a risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. More secure means of correspondence are always available, if you do not wish to transmit information vial email. By completing this form, I understand and am willing to accept the risks involved with in secure email communication of my protected health information. Tools for Life personnel may email me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_regarding my services and care.

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Individual/ Authorized Representative Signature Relationship (if applicable) Date