



ASSISTIVE TECHNOLOGY SERVICES AGREEMENT

Client Name: _____
Individual's Date of Birth: _____
Parent/Guardian's Name (if minor): _____

I, _____, hereby authorize AMAC Accessibility Solutions at the Georgia Institute of Technology, to conduct the 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, that the assistive technology evaluation/consultation may be observed by members of AMAC Accessibility Solutions and/or consultants of AMAC. I agree that AMAC Accessibility Solutions may audio-record, videotape, and/or take photographs, if needed, to assist with creating assistive technology solutions. These recordings and/or photos 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.

AUTHORIZATION FOR CONSENT:

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

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 via email. By completing this form, I understand and am willing to accept the risks involved within secure email communication of my protected health information. AMAC personnel may email me at _____ regarding my services and care.

Individual/ Authorized Representative Signature: _____

Relationship (if applicable): _____ Date: _____