Clarke Schools
for Hearing and Speech

80 East End Avenue
New York, NY 10028-8004

V 212.585.3500
FAX 212.585.3300

clarkeschools.org

2024-2025 Technology Intake Form

Name		Date of Birth	
Facility where child receives Audiology Services			
Managing Audiologist Name			
Managing Audiologist Email			
Phone & Fax Number			
Type/Degree of Hearing Loss			
Date of most recent UNAIDED audiological evaluation (less than one year old)			
Date of most recent AIDED audiological evaluation (less than one year old)			

	Hearing Aid or CI Manufacturer	Hearing Aid/CI Model	Serial Number
Right			
Left			

	Manufacturer	Model	Serial Number
FM Transmitter			
FM Receiver Right			
FM Receiver Left			

I hereby authorize the release of any and all Audiological information pertaining to my child ______________ (D.O.B. _____________) to the Clarke Schools for Hearing and Speech and by the individuals listed below:

Name /Address **Phone number** **Email address**	**Consent to Release Information (parent signature required on each line/name)**	**Consent to obtain information: (parent signature required)**
Audiologist:		
ENT/Otologist		

____
Signature of Parent or Legal Guardian

____
Date

This consent is valid for one year from the time of signature. Parents can revoke consent at anytime. Parents can limit consent at any time. Please speak to the Campus Director if a limited release is preferred.