



SOUTHEAST ALABAMA  
**Autism Center**

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**Consent and Confidentiality Agreement**

**Student Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_

**Parent/Legal Guardian Name:** \_\_\_\_\_

\_\_\_\_\_ I am providing my consent for Southeast Alabama Autism Center LLC. to provide Applied Behavior Analysis Services to my child. I understand that I may request information or terminate services at any time.

\_\_\_\_\_ I consent to participate if requested in a 1 hour per month parent training session to best understand my child's specific behavior intervention needs and skill acquisition programs.

\_\_\_\_\_ I consent to the ongoing of data collection and program evaluation.

\_\_\_\_\_ I understand that Southeast Alabama Autism Center LLC. Is not responsible for the actions of persons not employed by Southeast Alabama Autism Center.

(Please Initial each line and sign on the line below)

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_