



THERA-PLAY, PLLC

CONSENT FOR RELEASE OF INFORMATION

(Parent/legal guardian) _____, give permission for THERA-PLAY, PLLC to exchange information on child _____. By signing this form, I understand that THERA-PLAY, PLLC may contact the persons or agencies (i.e., physician, other therapy companies, school programs, etc.) listed below to obtain more information on my child, such as reports and/or evaluations. In addition, THERA-PLAY, PLLC may contact and send copies of goals, reports and other pertinent information to the agencies/individuals listed below.

Agency/Name: _____

Address: _____

Telephone: _____ Date: _____

Agency/Name: _____

Address: _____

Telephone: _____ Date: _____

Agency/Name: _____

Address: _____

Telephone: _____ Date: _____

Parent or Legal Guardian Signature

Date

Printed Name

THERA-PLAY, PLLC

Consent for Videotaping and Photographs for use at THERA-PLAY, PLLC

Therapist often videotape or photograph children who receive therapy services from THERA-PLAY, PLLC to help monitor and document a child's area of concern, as well as progress. Videotapes and photographs are used and reviewed only by THERA-PLAY, PLLC staff. Parents are welcome to view their child's videotapes/photographs.

PLEASE SELECT AN OPTION BELOW:

I do ___ do not ___ give consent for my child to be videotaped and/or photographed as part of his/her therapy program for use of THERA-PLAY, PLLC staff only.

Children also may receive therapy services in public places, such as a park.

PLEASE SELECT AN OPTION BELOW:

I do ___ do not ___ give consent for my child to receive therapy services from THERA-PLAY, PLLC in public places.

Parent or Legal Guardian Signature

Date