

**MICHELLE SOLOMON, M.A., CCC-SLP, PC**

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**Video Consent Form**

**Client's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please check all that apply

**Permission to Photograph and Videotape to share with caregivers/parents:** I give the treating therapist permission to photograph and/or videotape my child to be used for therapeutic and educational purposes. \*\*Short videos will be shared with parents and guardians via email or text.

**Permission to Photograph and Videotape to share with Speech Pathologists working in the practice:** I give the treating therapist permission to photograph and/or videotape my child to be used for therapeutic and educational purposes. \*\*Short videos will be shared with Licensed SLP's who are working within the Practice (Michelle Solomon, MA CCC-SLP, PC).

\_\_\_\_\_  
Parent or Guardian's Signature