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).

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Parent or Guardian's Signature