Therapedia #:_____

Therapedia™ LLC
Exceptional therapy for children.
phone (817)562-3111 fax (817)562-3114

CONSENT FOR RELEASE OF INFORMATION

I, _____, am the *(circle one)* parent / surrogate parent /

legal guardian of_____, date of birth_____
(Child's name)

and I hereby authorize **Therapedia, LLC** and the following named individuals/institutions/professionals along with the insurance company to RECIPROCALLY RELEASE AND DISCLOSE INFORMATION IN WRITTEN AND VERBAL FORM, DISCUSS MY CHILD, AND FORWARD CURRENT EVALUATIONS, PROGRESS REPORTS, AND NOTES BETWEEN:

Pediatrician:_____ Other Physician *(specify)*_____

Therapist (OT/PT/ST)_____ Teacher/Educator:_____

Psychologist:_____ Hospital: _____

Other *(specify):*_____

I also give permission for Therapedia to photograph/video my child, for the following purposes:

Purpose	**I consent (parent initials to consent)**	**I decline (parent initials to decline)**
Still photographs for:		
Evaluation and treatment purposes		
Education purposes		
Display on website, promotional materials, or social media		
Video Tape for:		
Evaluation and treatment purposes		
Education purposes		
Display on website, promotional materials, or social media		

_____*(initial)*If I decide to video/record parts of my child's session, I will inform the treating therapist and comply with requests to respect the privacy of the therapists or other children in the treatment areas.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

_____ ____/____/____ _____
(Parent/Guardian signature and date) (witness)