THERAPY SESSION RECORDING AUTHORIZATION

Speech Path & Pastures, LLC
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PATIENT INFORMATION

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Phone Number: _____

Email Address: _____

RECORDING PURPOSE

We request your permission to record video and/or audio of your child during their speech therapy evaluation. These recordings are intended solely for the following purposes:

- Clinical assessment and documentation
- Treatment planning and progress tracking
- Professional consultation and supervision
- Educational purposes within the clinic (e.g., therapist training)

RECORDING TYPE

Recording may include video, audio, and/or photographs.

CONFIDENTIALITY

All recordings will be stored securely with the patient's other records and kept confidential in accordance with HIPAA and applicable privacy laws. Recordings will not be shared outside the clinical team without your explicit written permission, unless required by law.

CONSENT

I, the undersigned parent or legal guardian of the child named above, hereby give my permission for the staff at Speech Path & Pastures, LLC to make and use video, audio, and/or photographic recordings of my child for the purposes described above. I understand that I may withdraw this permission at any time by providing written notice.

☐ I GIVE permission to record my child as described above.
☐ I DO NOT GIVE permission to record my child.

Signature of Parent/Guardian: _____

Date: _____

Relationship to Child: _____