LAKESHORE
SPEECH THERAPY, LLC.

LAKESHORE SPEECH THERAPY RELEASE FORM

PATIENT INFORMATION

Full Name	
Birthdate	
Address	
Phone Number	

PHOTOGRAPHY/VIDEO RELEASE:

Permission to record:	Yes No
Permission to video:	Yes No
Permission to photograph:	Yes No

RELEASE OF INFORMATION

Facility/Doctor/School Name 1	
Facility/Doctor/School Name 2	
Fax	
Email	
Evaluation/Progress Report/Discharge Note/Plan of Care:	Yes No

PARENT/GUARDIAN CONSENT

I, _____, as parent/guardian, hereby authorize Lakeshore Speech Therapy, LLC., to release/receive from any and all information contained in patient records. This consent is subject to revocation at any time in writing except to the extent the action has been taken thereon. Authorization and consent is valid for 2 years unless otherwise specified. The question of privacy between Lakeshore Speech Therapy, LLC and myself/patient, is waived.
I, as parent/legal guardian, hereby grant to Lakeshore Speech Therapy, LLC., the right to photograph/video record/use a photograph in any and all of its publications and in any and all other media, whether not known or hereafter existing. I understand and agree that these materials will become the property of Lakeshore Speech Therapy, LLC and will not be returned. Additionally, I waive any right to any compensation arising or related to the use of the photograph/recording.

Signature	Date