SLT THERAPY, PLLC

PERMISSION TO OBTAIN SERVICES VIA SKYPE/FACE TIME

THIS INFORAMTION IS ENTIRELY CONFIDENTIAL

You have requested to receive services via Skype/Face Time. These are free, downloadable internet software applications that allow users to transmit video streaming over the internet, via webcam; and/or to share various kinds of files. To participate in this service, please provide the required permission and information on the form below:

Name of Patient: _____
Email: _____Phone: _____
Address: _____
City: _____State: _____Zip: _____

We take precautions in suing web cameras in an attempt to protect your privacy. However, since Skype/Pace Time are public series, you need to be aware that sending information over the internet does include the risk of personal information being accidently disclosed to other people (i.e., on the web). For this reason, we need your permission to utilize our services via Skype/Face Time.

___ Yes, I give my permission to utilize services via Skype/Face Time.

___ No, I do not give my permission to utilize services via Skype/Face Time.

_____ _____
Patient Signature Date

_____
Signature of Parent or Legal Guardian, if Minor