



21-14 Newtown Avenue
First Floor
Astoria, NY, 11102
Tel: 718.545.0958

Photograph & Video Consent & Release Form

I hereby authorize the LEAPS AND BOUNDS PHYSICAL THERAPY AND OCCUPATIONAL THERAPY, PLLC to use the photographs and video taken of myself or my minor child during the exercise sessions for educational, informational and promotional materials.

I understand that the LEAPS AND BOUNDS PHYSICAL THERAPY AND OCCUPATIONAL THERAPY, PLLC also serves as a training and research facility and at times other therapists may be observing, handling, or have access to my child's medical information. I give my permission for the above interaction to take place for educational and research purposes.

Parent or Guardian Signature: _____

Date: _____

Patient Signature: _____

Date: _____

If you would like to receive a copy of any publication, which includes your photograph or if you would like to be on our mailing / e-mail list, please give us your address and e-mail:

Signer's Name: _____

Address: _____

Phone #: _____

Name: _____

E-mail: _____