YOUR LOGO
(optional)

CLINIC / PRACTITIONER NAME

Form OT-CONS-01

Address · phone · license #

Occupational Therapy Consent Form

Consent for evaluation and treatment, information sharing, and related permissions.

CLIENT INFORMATION

Client name

Date of birth

Medical record # / ID

Date

Parent / guardian / representative

Relationship to client

Description of services — purpose, expected benefits, and possible risks

I CONSENT TO — check all that apply

- ☐ Occupational therapy evaluation
- ☐ Occupational therapy treatment
- ☐ Telehealth / remote sessions
- ☐ Exchange of information with the providers listed below
- ☐ Photography or video for clinical documentation
- ☐ Photography or video for education or marketing
- ☐ Participation of students, observers, or assistants
- ☐ Financial responsibility for services rendered

NAME	ORGANIZATION	RELATIONSHIP	PURPOSE

Limitations, exclusions, or additional notes

ACKNOWLEDGEMENT & SIGNATURES

I have had the opportunity to ask questions, I understand I may withdraw consent in writing at any time, and I consent voluntarily.

Client / guardian signature

Date

Clinician or witness signature

Date