| [**Covered Entity/ Logo**] | **AUTHORIZATION FOR CASE REPORT** |
|---|---|

| Resident Name: | | DOB: | |
|---|---|---|---|
| Address: | | | Phone#: |
| City: | State: | Zip: | Email: |

Your therapist would like to prepare and present a Case Report highlighting the exceptional progress you made with your therapy goals. The intent of the Case Report is to share a case that is encountered in the clinical practice, describe how a specific treatment or intervention affected a patient's outcome, or demonstrate how research, clinical experience, and patient choice was integrated into a certain treatment intervention. Case Reports are shared with other clinicians for learning purposes.

The Case Report may include the following additional information about you:

- Your first and last initials
- The facility's name
- Photograph
- Videotaping

I understand that this authorization is voluntary. Refusal to sign will not affect my ability to receive services. I understand that my information will be shared with other professionals within and outside facility after I have signed this form, I may change my mind and revoke my authorization by notifying the facility in writing and understand that my information may have already been shared.

☐ I authorize the use and sharing of my <u>first and last initials,</u> <u>photograph</u> AND <u>videotaping</u> in the Case Report.

| Signature of Individual (or Authorized Representative) | |
|---|---|
| Printed Name and Date of Person Signing | Date |
| Authorized Representative's Relationship to Individual | |