Audio/ Photography Consent Form

I _____ (Name of person giving consent & parent/guardian if under 18 years of age) consent for Premier Pediatric Therapy, P.A. to photograph and/or take audio/video recordings of my child. I authorize_____ (Name of Child) for use on the Premier Pediatric Therapy, P.A. website, newsletters, and for therapeutic speech and/or language sampling. I acknowledge that by giving consent, my child's name, diagnosis, or any other identifiable personal and/or health related information *will not* be published.

I further understand that this consent may be withdrawn by me at any time, upon written notice.

I give consent voluntarily.

_____
Signature of person giving consent

Date: _____