# PHOTO PERMISSION

Client's Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

**Please check all that apply:**

□ I grant permission for photography/videotaping for treatment and documentation purposes.

□ I grant permission for photography/videotaping for education and training purposes.

□ I grant permission for photography/videotaping for printed advertising materials (i.e. brochures).

□ I grant permission for photography/videotaping for online advertising materials (i.e. website, Facebook).

□ I decline all photography/videotaping of my child for any purpose.

I confirm that I agree with the selections above regarding photographing and/or videotaping my child by Peak Pediatric Therapy, LLC and I will contact Peak Pediatric Therapy in writing should I decide to alter my selections.

Printed Name of Parent/Guardian: _____ Relationship to Client: _____

Signature: _____ Date: _____