

Speak Freely

Speech–Language and Oral-Motor Services

PHOTOGRAPHY AND VIDEO RELEASE FORM

I hereby authorize Speak Freely to photograph or video my child for the purposes of treatment, education, and professional reasons. I also understand that my child may be in group pictures or videos that may also be reviewed by others outside of Speak Freely. I also understand that if pictures of my child are used for advertisement or marketing purposes, Speak Freely will request consent from me prior to use of the pictures of my child.

This authorization is valid for the duration of my child's therapy from the date signed below. I understand that I may revoke this authorization at any time, but will not hold the therapist and/or staff of Speak Freely responsible for pictures or videos already taken on my child.

Name of Child: _____

Parent's Name: _____

Parent's Signature: _____

Date: _____