

In Harmony Pediatric Therapy

Consent for Audio/Visual Release

I _____ (Parent or Legal Guardian) give permission for _____ (Name of Child) to be audio or video taped by the therapists at In Harmony Pediatric Therapy. These audio or video taped sessions will be used for education and training purposes only (i.e., clinical supervision, conference presentations). At no time will your child's full name be spoken on the tapes and your child's full identity will remain confidential. These tapes may be maintained in a locked facility.

Signature of parent/guardian: _____

Date: ____ / ____ / ____

Consent of Photograph Release

I _____ (Parent or Legal Guardian) give permission for my child _____ (Child's Name) to be photographed by the therapists at In Harmony Pediatric Therapy. These photographs will be used for education and training purposes (i.e., clinical supervision, conference presentations), and may be used by In Harmony Pediatric Therapy for advertisement purposes (i.e., brochures, newspapers).

Signature of parent/guardian: _____

Date: ____ / ____ / ____