

## **PHOTO/VIDEO RELEASE FORM**

I understand that FirstRowe Speech Pathology, P.C., may time to time, take photographs or produce films or videotapes for various educational purposes, including, without limitations, clinical and educational activities and provide information about the therapy session to professional organizations and individuals and to others, and for other educational purposes.

I consent and grant permission to FirstRowe Speech Pathology, P.C., to include me and or my child and/or my family in any such photographs, films, or videos or including any of our speech or voices, and to use or publish such photographs, films or videos in any publications or any media in connection with any educational purpose described above without any payment or compensation to myself and my family and I waive all of my rights to these materials. I understand that ***my child's full name*** (if applicable) ***will not be used*** in connection with any such use or publication or photographs and videos.

Child's Name \_\_\_\_\_ Name of Parent \_\_\_\_\_

Parent Signature \_\_\_\_\_ Phone Number \_\_\_\_\_