PENINSULA ASSOCIATES
SPEECH THERAPY SERVICES

PASTS PHOTOGRAPHING/VIDEOTAPING RELEASE FORM

Client Name: _____

(Please check one)

☐ I give permission for Peninsula Associates Speech Therapy Services to photograph/videotape my/my child's speech session, including my/my child's image, likeness and voice, without compensation. I understand that the photo(s) or video(s) will be used for **assessment and treatment purposes and will only be viewed by clinicians at Peninsula Associates.** This authorization is continuous and may be withdrawn only by my specific written instructions.

☐ I give permission for Peninsula Associates Speech Therapy Services to photograph/videotape my/my child's speech session, including my/my child's image, likeness and voice, without compensation. I **understand that the photo(s) or video(s) may be used for training or digital or print marketing**. This authorization is continuous and may be withdrawn only by my specific written instructions.

☐ I do **not** give permission for Peninsula Associates to photograph/videotape my/my child's speech session.

_____ _____

Client/Parent Signature Date

_____

Print Client/Parent Name