Authorization for Use of Photographs

I, _____ herby authorize
(Patient or Legal Guardian's name, printed)

_____ to take photographs
(Clinic/Therapist, printed)

of me, my child, or of the person for whom I am a legal guardian, for the purpose of treatment planning.

_____ I further give my permission for these photographs to be used for educational purposes.
(Initials)

Patient printed name: _____

Guardian printed name: _____

Patient/Guardian signature: _____

Witness printed name: _____

Witness Signature: _____

Date: _____

Facility Name
Facility Address
Facility phone, fax, and email