Authorization for Use of Photographs

I, ______________________________________________________ (Patient or Legal Guardian’s name, printed) hereby authorize ______________________________________________________ (Clinic/Therapist, printed) to take photographs of me, my child, or of the person for whom I am a legal guardian, for the purpose of treatment planning.

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

Patient printed name: _____________________________________________________
Guardian printed name: ____________________________________________________
Patient/Guardian signature: ________________________________________________
Witness printed name: _____________________________________________________
Witness Signature: ________________________________________________________
Date: ___________________________________________________________________

Facility Name
Facility Address
Facility phone, fax, and email

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