

Performance Pediatrics Media Release Form

I, _____, the parent/guardian of a child/children at Performance Pediatrics, agree to the following:

I understand that my child(ren) whose name(s) are listed below may be photographed or videotaped at the clinic. These photographs may be used in promoting child therapy services, either in print or on the internet.

The child(ren) are known as:

With my signature below, I grant permission for my child(ren) to be photographed, or their images recorded for print or electronic use in promoting Performance Pediatrics' Therapy Services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above use. I agree that this form will remain in effect for the duration of my Childs care at Performance Pediatrics.

Accept: _____ Decline: _____

Parent/Guardian Signature: _____

Date: _____

Thank you!