

## AUTHORIZATION TO DISCLOSE INFORMATION

### Photo/Video Release

I, \_\_\_\_\_ hereby consent to the use of video and/or photos of myself and/or my child \_\_\_\_\_ . I understand that they may be used by Neurotherapeutic Pediatric Therapies dba Medford Children's Therapies (MCT) and its assignees or successors for as long as they deem necessary and for the purpose of demonstrating services rendered by this clinic in the specific arenas marked below (please initial).

\_\_\_\_\_ MCT4kids social media and website

\_\_\_\_\_ Promotional or educational materials

\_\_\_\_\_ In-house use

\_\_\_\_\_ All of the above

In the course of using the above, I understand that MCT's use of the video and/or photos may disclose the following information regarding my child (please initial).

\_\_\_\_\_ Disabling condition/diagnosis

\_\_\_\_\_ Age/Grade level

\_\_\_\_\_ Type of treatment received

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Parent Guardian Signature

\_\_\_\_\_  
Date