



Release for Photography/Videotaping (optional)

Parent/Guardian Name(s): _____
(Please Print)

I hereby authorize 7 Senses Therapy, LLC to take and or display photographs, videotapes, movies or video recordings or utilize quotations of _____.
(Child's Name) (Please Print)

This permission includes the following: Documentation of progress, parent training, research, education, publication, company literature, advertising, in the clinic, website production, social media, and background scenes during taping or photography of other patients.

I further consent that such videos, films, photographs or biographical information may be used by 7 Senses Therapy, LLC completely free of any compensation.

X _____ Date: ____/____/____
Parent/Guardian Signature