MICHELLE FOOSANER, MS PT
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Photo and Video Consent

Children's Therapy Associates has permission to take photos and video footage of me and/or my child, (print child's name)___________________________, for the purposes indicated below. I understand that my/my child's name and other identifying information will be kept confidential.

Please initial if granting consent, or draw a line through the space provided if denying consent.

1. To create a comprehensive home exercise program. __________

2. For training, educational, and/or collaborative purposes with new and/or potential contractors and professional associates of Children's Therapy Associates. ___________

3. For promotional purposes to be included in brochures, presentations, web sites, etc. ___________

Signature of patient/parent/guardian: ________________________Date: ___________________

Please print: __________________________Relationship to Patient: ______________________