

LITTLE HOUSE ON MACKINAW

CONSENT/AUTHORIZATION

PHOTOGRAPHY/VIDEOTAPING/OTHER IMAGING/AUDIO RECORDING FOR TREATMENT, EDUCATION, MARKETING OR MEDIA PURPOSES

Client Name: _____ DOB: _____

Address: _____ Phone Number: _____

I hereby give my consent to have photographs, videotaped images, other images, or audio recordings made of my family member or myself for the following purposes:

- _____ Educational Purposes – Type: _____
- _____ Treatment Process/Documentation: _____
- _____ Publicity/Publication Purposes – Type: _____
- _____ Event: _____
- _____ Other: _____

Type of recording: Photograph Video Audio

This Consent does not have an expiration date.
 does have an expiration date of _____

WITHDRAWAL OF THIS CONSENT CAN BE DONE BY CONTACTING, VIA WRITTEN NOTICE, TO THE ADDRESS ON THE FOOTER OR BY SENDING AN EMAIL TO YOUR THERAPIST.

Signature of Client or Legal Representative/Relationship _____ Date _____

Witness _____ Date _____