AUTHORIZATION TO USE PATIENT'S LIKENESS FOR PUBLIC RELATIONS AND FUND RAISING PURPOSES

I understand that the Pediatric Therapy Clinic, Inc. is a charitable organization which depends upon public financial support to operate its clinics, because it makes no charges to its patients or families for the services it renders. I also understand that the Pediatric Therapy Clinic, Inc. engages in public relations programs and fundraising programs designed to make the public aware of the clinic's needs, which include financial support, and to inform the public of the availability of the clinic's services.

I have been asked for permission to use photographs, audios or similar "likenesses" of my child if I am the child's parent or legal guardian, in the Pediatric Therapy Clinic's public relations programs and fundraising programs, and I have been assured that permission is not required as a condition to my child receiving therapy services at the clinic.

I wish to help the Pediatric Therapy Clinic, Inc. in its public relations and fundraising programs, and I consent to photographs, slides, television, videotape, or motion pictures (called "likenesses") being taken of _____ or parts of his or her body, for public relations and fundraising purposes, subject to the following conditions:

(1) The last name of either the child or the parent or guardian will not be used to identify the "likenesses," unless I/we have initialed here: _____.

(2) The "likenesses" will be taken only with the consent of the treating therapist(s) and/or the clinic director and under conditions, and at times, as may be approved by them.

(3) The "likenesses" will only be used in Fundraising and Public Relations Media for five years from the date I signed this consent.

I can revoke (take back) this authorization at any time by notifying the Pediatric Therapy Clinic, Inc. However, revoking this authorization will not affect any materials that were already distributed based on my previous authorization.

I also understand that these "likenesses" may be distributed by other people (such as passing on their copy of a "likeness") and the Pediatric Therapy Clinic, Inc. has no way to prevent this from happening.

I have been given an opportunity to ask questions about this authorization, and either had no questions or they have been answered to my satisfaction.

I expect no payment or anything else valuable for signing this authorization. Also, this authorization as to any use of photographs, slides, television, videotapes or motion pictures will expressively release from liability to me the person obtaining the "likeness," the treating therapist(s), the clinic and all it's personnel, The Pediatric Therapy Clinic, Inc and it's partner, The Scottish Rite Masons, their officers and members.

_____ I <u>do not</u> wish for my child's picture to be used. (initial)

_____ _____
Parent/Legal Guardian Signature Date

_____
Address City State Zip

_____
Phone Number

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