



# Amazing Kidz

Therapy, PLLC

## **Media Release and Consent**

Please choose ONE of the following options to indicate your preference for your child.

- I hereby authorize Amazing Kidz Therapy, PLLC to photograph and/or videotape my child to utilize for any and all marketing, social media and/or publications as they see fit.
  
- I hereby authorize Amazing Kidz Therapy, PLLC to photograph and/or videotape my child ONLY during group therapy treatment sessions, where my child will not be the only child within a picture, to utilize for any and all marketing, social media and/or publications as they see fit. I DO NOT authorize individual pictures of my child to be utilized.
  
- I DO NOT authorize Amazing Kidz Therapy, PLLC to utilize any photographs of my child for marketing, social media or other purposes.

Childs Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Relationship to Child: \_\_\_\_\_