

**PERMISSION TO PHOTOGRAPH, AUDIO-
AND/OR VIDEOTAPE**

I, _____, authorize _____
to photograph, audiotape, or videotape myself and/or my child, _____
_____.

These recordings may be used for the following purposes:

Feedback to be used for therapeutic intervention _____
initial

Research purposes _____
initial

Educational purposes _____
initial

The therapist agrees to maintain anonymity of my own and my child's name.

Parent's Signature _____ Date _____

Therapist's Signature _____ Date _____