



Bothell Pediatric & Hand Therapy

Photo/Video Authorization

Consent to Photograph / Video and Authorization for Use of Photograph or Likeness

I, (printed name) _____, permit and authorize Bothell Pediatric and Hand Therapy and its employees, agents and personnel who are acting on behalf of the clinic to use my or my child's photograph or other likeness for purposes related to the mission of the clinic, including but not limited to treatment, publicity, marketing and promotion of the clinic and its programs. I understand that photos or videos will also be released to my physician upon request, and kept as part of the patient's permanent file. I understand that my or my child's photograph or likeness may be copied and distributed by means of various media, including but not limited to video presentations, television, news bulletins, mail-outs, billboards or signs, brochures, newspapers or placement on the Bothell Pediatric and Hand Therapy website.

My Name

Date

My Child's Name

Comments