Release of Photographs/Videos

I, _____ give Kelly Benson-Vogt permission to photograph and/or record my child, _____ during evaluations and/or treatment sessions for use in research, educational presentations, or to show progression of his/her skills. Additional confirmation will be made if photographs are to be used for promotional purposes. Your child's last name or any other identifying information will never be used when photographs or video clips are used. You may revoke this release at any time by contacting Kelly Benson-Vogt at Pediatric Feeding & Speech Solutions, PLLC.

Signature_____Date_____

Therapist _____ Date _____

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