MUSIC THERAPY CLINIC
AT GEORGIA COLLEGE

AUDIO/VISUAL/PHOTOGRAPH RELEASE FORM

CONSENT FOR AUDIO/VISUAL RELEASE

I ____________________ (Parent or Legal Guardian) give permission for
________________________________ (Name of Child) to be audio or video taped by the therapists at the
Music Therapy Clinic at Georgia College. These audio or video taped sessions will be used for
educational and training purposes only (i.e., clinical supervision, conference presentations). At no time
will your child’s full name be spoken on the tapes and your child’s full identity will remain confidential.
These tapes may be maintained in a locked facility.

If you do not give permission then leave the above blank and initial the following:

_____ I decline the taking of audio/visual material

PRINTED NAME

RELSHIP TO Client

CLIENT OR GUARDIAN SIGNATURE (IF UNDER 18)

DATE

CONSENT FOR PHOTOGRAPH RELEASE

I ___________________________ (Parent or Legal Guardian) give permission for
________________________________ (Name of Child) to be photographed by the therapists at the
Music Therapy Clinic at Georgia College. These photographs will be used for educational and training
purposes (i.e., clinical supervision, conference presentations), and may be used by the Music Therapy
Clinic at Georgia College for advertisement purposes (i.e., website, brochures, newspapers).

If you do not give permission then leave the above blank and initial the following:

_____ I decline the taking of photographs

PRINTED NAME

RELSHIP TO Client

CLIENT OR GUARDIAN SIGNATURE (IF UNDER 18)

DATE