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 RELATIONSHIP 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 RELATIONSHIP TO CLIENT

_____

CLIENT OR GUARDIAN SIGNATURE (IF UNDER 18) DATE

GEORGIA COLLEGE
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