



CONSENT TO PHOTOGRAPH, AUDIO, OR VIDEO RECORD

Client name: _____

I, _____ do hereby give my permission and authorization to Family Solutions, PLLC to create the following record for the purpose described below. I understand that any such record will be kept confidential.

Type: ___ Photograph
 ___ Video
 ___ Audio

Purpose: ___ Diagnostic
 ___ Research
 ___ Therapeutic
 ___ Training

I understand that this consent will expire in one year and may be withdrawn at any time.

Signature of Client/Guardian

Signature of Witness

Date

Date