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**CONSENT FOR PHOTOGRAPHS/AUDIOVISUAL MATERIAL**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ father/mother/guardian *(please circle)* of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(client’s name),* born on

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child’s date of birth)* give permission for

Not All Talk Speech Pathology to obtain ~~photographs/~~ audiovisual material for the purpose of: (please tick- a selection has been recommended, for your assistance).

€ Providing a service to my child

€ Recording a session

€ Promotional material

€ Training purposes

***Details: All recordings to be provided to family within 24 hours of a session.***

***All recordings will be deleted from system once family have confirmed file was received.***

Signed: .

Relationship to child: .

*Please note: Consent is only valid for the duration of therapy and can be cancelled upon request at any time.*