



Videography/Photography/Audio Release Form

Name: _____

Date of Birth: _____

Parent/Guardian's Name: _____

I understand that photography/audio/video recordings of my child and/ or myself are made at no extra cost to me and that I may request to view them. This and the nature of the images and/or recording procedures have been explained to me. I understand that the images and/or audio records are confidential material and will not be used without my specific consent. I understand that I may withdraw my permission by written request at any time.

Employees/staff/Contractors of the Els for Autism Foundation may use these photographic images, video segments or audio segments for reasons other than therapeutic purposes:

Initial Please choose one:

_____ I give **consent** for my child's or my own image and/or voice to be used for educational, training, and research purposes (e.g., national/international conferences or trainings/conferences).

_____ I **decline** to give consent for my child's or my image and/or voice to be used for educational, training, and research purposes (e.g., national/international conferences or trainings/conferences).

Initial Please choose one:

_____ I give **consent** for my child's or my own image and/or voice to be used for publication purposes (e.g., textbooks, journal articles or conference publications).

_____ I **decline** to give consent for my child's/ my image and/or voice to be used for publication purposes (e.g., textbooks, journal articles or conference publications).

Initial Please choose one:

_____ I give **consent** for my child's or my own image and/or voice to be used for fundraising purposes.

_____ I **decline** to give consent for child's or my own image and/or voice to be used for fundraising purposes.

Initial Please choose one:

_____ I give **consent** for my child's or my own image and/or voice to be used by commercial and/or non-profit entities associated with the Els for Autism Foundation and/or the Els Center of Excellence whose purpose is to disseminate information about the School, the Foundation's events and programs, and the Centers' facilities.

_____ I **decline** consent for my child's or my own image and/or voice to be used by commercial and/or non-profit entities associated with the Els for Autism Foundation and/or the Els Center of Excellence, whose purpose is to disseminate information about the School, the Foundation's events and programs, and the Center's facilities.



Your ability to receive services through the ELS for Autism Foundation is not affected in any way by your willingness to consent to your own or your child's image being used for either educational, training, research, fundraising, informational or publication purposes as described above.

Parent/Guardian Signature

Date

Parent/Guardian Printed Name

Program

Signature of Person Obtaining Consent

Date

Printed Name of Person Obtaining Consent

If you have further questions about the information on this form, you may contact Erin Brooker Lozott, M.S., CCC-SLP (Assistant Director of Clinical Services) for further information.