COMMUNICATION CIRCLES

Name		DOB:	Phone:
Parent			Phone:

CONSENT TO PHOTOGRAPH/TEXT/EMAIL

I, ____________________________, parent/ legal guardian of

____________________________, a current client with Therapy Circles, hereby authorize my therapist or other designated person to take:

1. **Photographs of child for identifications purposes. _____YES _____NO**
2. **Photographs of child to provide supporting documentation of my child's medical condition. _____YES _____NO**
3. **Photographs of my child for the purpose of professional education of treating therapist. _____YES _____NO**
4. **Photographs of my child for the purpose of marketing and training for Therapy Circles, Bridging Apps, Apple, ACT and other conferences and conventions. _____YES _____NO**
   (Specify) __________________________________
   ____
   ____

5. Send text messages to parents containing information about the patient and treatment. _____YES _____NO
6. Send email messages to parents containing information about the patient and treatment. _____YES _____NO

Responsible Party's Signature:
____

Printed Name: __________________________ Date: _______

Relationship to Client: ____