



Scottish Rite Childhood Language Center
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AUTHORIZATION FOR MEDIA RELEASE

I authorize the Scottish Rite Childhood Language Center to:
 (Please initial all that apply)

_____ video tape, audiotape or photograph
 evaluation/therapy sessions of my child for
 the purposes of data collection, review and/or conducting
 therapy. This information may not be used for any other
 purpose without my expressed written consent.

_____ photograph my child during evaluation/treatment sessions.
 I understand these photographs may be used to promote the
 the Scottish Rite Childhood Language Center as a non-
 profit children's charity. These photographs may be used
 at the discretion of the Scottish Rite Childhood Language
 Center for such intended purposes, including but not limited
 to newsletters, publications and fund raising activities.

_____ allow Speech-Language Pathology/Audiology students to
 observe my child during evaluation/treatment sessions. I
 understand this is for the purpose of educational training,
 and is a required component of their curriculum.

_____ allow potential contributors to observe my child during
 evaluation/therapy sessions. I understand this is done to
 increase awareness and support of speech and hearing
 disorders, and to promote the work of the Scottish Rite
 Childhood Language Center.

The Scottish Rite Childhood Language Center will not condition my
 child's treatment or enrollment in the program on whether I
 provide authorization for the requested use or disclosure.

Signature of Parent or Guardian

Date

Witnessed by

Date