Photo/Video Consent Form

Parent CONSENT

I,_____, _____ First name, Last name DOB , Parent of children named below:

_____ (Full name of child and DOB)

consent to all images and / or video being made of me or my child/dependent not limited to one date of service. I agree that images may be used for social media purposes including Kidsville Pediatrics website, Facebook Page, Newsletter, or Instagram. Kidsville Pediatrics has full rights to use the photo/ videos in any form of marketing/advertisement.

I further acknowledge that there were no promises of compensation for such use of medical photo(s) and or video taken by Kidsville Pediatrics, PLLC staff as consented above.

This consent maybe revoked at any time with written request by patient.

By signing below, I confirm that I understand this consent form.

_____ _____

Signature of Parent/Guardian Date