Kid O' Therapy, LLC
41 Main Street
Topsham, Maine 04086
P: (207) 844-8287
F: (207) 844-8245
www.kidotherapy.com

Consent and Release for Use and Disclosure of Image, Voice, and/or Written Testimonials

I, _____ consent to the photographing, recording and unlimited use of my likeness (including my name, voice, and/or Image) for commercial, promotional or other use, in any medium, including use on the internet and social media, by Kid O'Therapy, LLC and its employees, affiliates, subsidiaries, Licensees, successors, and assigns. I waive all rights of attribution, inspection, or approval for any use of my likeness. I understand that Kid O'Therapy, LLC has no control over how my photos, videos or testimonials may be used by others once they are published on the internet. Kid O'Therapy, LLC and its employees, affiliates, subsidiaries, licensees, successors, and assigns are held expressly harmless for any liability, legal, and/or financial, incurred as a result of said use. I waive any right to royalties or other compensation arising from or related to the use of my likeness. All right, title, and interest to any photographs, recordings, and any other materials using my likeness shall be the sole property of Kid O'Therapy, LLC. I shall have no interest in any such materials, nor shall I have any right to use the name or trademarks of Kid O'Therapy, LLC without its express, written permission. If I decide I do not want Kid O'Therapy, LLC to use my photos, videos, testimonials or other likeness, I may revoke this Consent and Release for new future uses but Kid O'Therapy, LLC shall have no obligation to remove my photos, videos, testimonials or other likeness in its promotional, commercial, educational, or other materials that are already in use.

I HEREBY ACKNOWLEDGE THAT KID O'THERAPY, LLC OR ANY OF ITS AGENTS OR EMPLOYEES HAVE NOT MADE ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND WITH RESPECT TO ANY MEDICAL OR OTHER ADVICE OR INFORMATION THAT I MAY RECEIVE IN CONNECTION WITH MY APPEARANCE AND THAT I HAVE NOT RELIED ON ANY SUCH REPRESENTATIONS OR WARRANTIES IN AGREEING TO PARTICIPATE IN THE RECORDING OF MY VOICE AND/OR LIKENESS AS DESCRIBED ABOVE OR IN THE EXECUTION OF THIS CONSENT FOR USE AND DISCLOSURE OF IMAGE, VOICE AND/OR WRITTEN TESTIMONIALS (THE "CONSENT").

I am signing this Consent and Release voluntarily, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs, and assigns. I understand that this Consent will be signed contemporaneously with the form entitled Authorization for Use and Disclosure of Protected Health Information for Marketing and Promotional Purposes (the "Authorization"), and I agree that in the event of conflict between the two documents, the terms of the Authorization shall govern.

Printed Name: _____

Signature: _____ Date: _____

-If I revoke or cancel this authorization, I understand that the revocation will not apply to Protected Health Information that has already been used or disclosed in reliance on my authorization.
-I am entitled to receive a copy of this Authorization upon request.
-Unless I revoke this authorization, it will expire 30 months from the date signed below.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

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Legal Representative (Print name, if applicable): _____

Legal Representative Signature: _____ Date: _____

Legal Representatives Relationship to Patient (if applicable): _____