Authorization for Photography and/or Videotaping
And Release from Liability

I, _____

Or I, The Parent and/or Guardian, of _____

a patient at _____,

authorize members of the University of Tennessee at Chattanooga, Department of Physical Therapy, to take photographs and/or videos, which will only be used for educational purposes, and will not be shared with anyone outside of the Department of Physical Therapy. I release the Department of Physical Therapy from any and all liability resulting from said photography/videotaping.

_____	_____
Signature	Witness
_____	_____
Date	Date