ATLANTA PEDIATRIC PARTNERS MEDIA CONSENT FORM

I, _____ grant permission and give my consent to allow Atlanta Pediatric Partners to use _____ For the use of the following photograph(s), video(s), or electronic media images on social media platforms, and our company website.

Revocation (check one)

☐ I understand that my authorization below the photograph(s) and/or video(s) may never be revoked.

☐ I understand that I may revoke this authorization at any time by notifying _____ in writing. The revocation will not affect any actions taken before the receipt of this written notification. Images and/or videos will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or achieved.

Parent Signature _____ Date _____

Witness Signature _____ Date _____