AUTHORIZATION OF USE AND DISCLOSURE OF
PHOTOGRAPHY/VIDEO

I, _____, authorize O.T. Plus, Inc. to take and or reproduce photographs/video of me for:

_____

Description of photographs/video to be taken: _____

_____

Type of information to be disclosed:

( ) Access to complete record
( ) Physician, medical, and/or therapy reports
( ) Records of participation in program
(X) Photograph

Purpose of disclosure:

( ) Subsequent treatment
( ) Insurance or Workers Comp
( ) Litigation
( ) At the request of the patient/patient representative
(X) Educational materials

This consent expires upon the following condition(s) unless expressly revoked by me:

( ) Upon satisfaction of the need for disclosure
( ) One year from the date noted below
( ) Other date:_____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must submit a letter to O.T. Plus, Inc.

The photos or images specified above become the property of O.T. Plus, Inc. or its representatives.
This Authorization is given without promise of compensation. The client releases to O.T. Plus, Inc. any right, title and/or interest of any kind they may have in the information or images produced.

A facsimile of this authorization with my signature may be used with the same effectiveness as an original.

Signed_____ Date_____
(Client or authorized representative)

Relationship (if signed by representative)_____

Witness_____

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