Photo Release Form

I, _____, the parent of a child/children at Sunshine Pediatrics of St. Augustine (Hereinafter known as the "Practice"), agree to the following:

I understand that my child(ren) whose name(s) are listed below may be photographed at the Practice during normal office hours, appointments, or activities. I understand that these photographs may be used in promoting pediatric care services, either in print or on the Internet.

The child(ren) are known as: _____.

With my signature below, I grant permission for my child(ren) to be photographed, or their images recorded for print or electronic use in promoting the Practice's services. I understand that it is my responsibility to inform the Practice in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect until I revoke permission. I understand that there will be no payment for me or my child's participation in this release.

Revocation of Permission: If at any time I wish to revoke this permission, I understand that I must notify Sunshine Pediatrics of St. Augustine in writing. This revocation will take effect upon receipt of my written notice and will not affect any photos or recordings taken prior to the receipt of such notice.

Parent/Guardian Signature _____ Date _____

Relationship To Child _____