Serenity Therapeutics LLC

753 North Main St, Suite B5, Cottonwood AZ 86326

928-899-0723 info@SerenityTherapeuticsLLC.com

PHOTO RELEASE FORM

I, ________________________________, the parent of ________________________________ agree to the following: I understand that my child whose name is listed below may be photographed while attending a therapy session. I understand that these photographs may be used in promoting therapy services, either in print or on the Internet. The child is known as:________________________________. With my signature below I grant permission for my child to be photographed, or their images recorded for print or electronic use in promoting Serenity Therapeutics, LLC. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

Parent/Guardian Signature ____________________________

Date _______________________

Relationship To Child ____________________________