Niagara Therapeutics Inc

Authorization for Use of Photographs

I, ____ hereby authorize

Patient or Patient's legal Guardian name, printed)

Beth Elliott, R.M.T, CLT of Niagara Therapeutics Inc. to take photographs of me, my child, or the person for whom I am a legal guardian, for the purpose of treatment planning.

________ I further give my permission for these photographs to be used for educational purposes.

Initials

Patient printed name: ____

Guardian printed name (if applicable):____

Patient/Guardian Signature: ____

Witness Printed name: ____

Witness Signature: ____

Date: ____________________________________