Houston Pediatric Pulmonary and Sleep Associates
Permission to Photograph

I give permission to the staff and physicians of Houston Pediatric Pulmonary and Sleep Associates to photograph my child _________________________for the following reasons:

___X____ Chart Identification - ONLY

I understand that the physicians and staff intend to use this photograph only for the purpose checked above.

I also understand that the child's identity will be kept confidential.

I AGREE to allow my child to be photographed as listed above.

_________________________________ ________________________
Signature Date

I DO NOT agree to allow my child to be photographed as listed above.

_________________________________ ________________________
Signature Date