DOCTORS CARE
Accessible Care for the Underserved

Photo Release Form

DATE:

I hereby grant permission to Doctors Care to use my or my child's photograph in its materials or Web site, and I acknowledge their right to crop or treat the photograph at its discretion.

This consent covers the use of still photographs, video and other types of recordings, and the release of information necessary to accompany such photographs. I understand that this consent also covers release of general information about me and my family members. I also acknowledge that the photo may not be used at this time, but it may be used at a later date.

I release Doctors Care, its officers, directors, agents, employees and physicians from all liability and all claims of any nature pertaining to the photographs, films or tapes or the release of associated information about me or my family members.

- - -- -

NAME: ____

ADDRESS: ____

CITY, STATE, ZIP: ____

E-MAIL ADDRESS: ____

HOME PHONE: _________________CELL PHONE: _____________

TODAY'S DATE: ____

SIGNATURE____

Photo description:

Immediate purpose or project: