Authorization to Release and Disclose Photographs

This photographic release pertains to photographs taken following treatment(s).

I, _____ (print name), voluntarily consent to the copyright publication and use of my picture and likeness by Pocatello Wellness Clinic and its affiliates, successors, and assignees.

I agree that any pictures taken of me are usable for teaching or publication purposes unless I notify the practice in writing that my photographs are not to be used. I agree that this constitutes full disclosure and that it supersedes any verbal or written disclosures. I understand that if the pictures have already been published, that their use cannot be undone and that disclosures only can apply for any future or new use.

I hereby release _____ from a claim demand, cause, action or proceeding of whatever nature arising out of publication and distribution of the said photographs in accordance with the terms.

I understand that once my photographs have been disclosed to _____the photographs will no longer be protected by federal privacy laws. However _____ will not use the photographs except as permitted on this authorization form. I understand that I will be given a signed copy of this form if I desire.

Patient Signature _____ Date: _____

Patient Name (print) _____

Witness Signature _____ Date:_____

Witness Name (print) _____