central oregon
EAR | NOSE | THROAT

CONSENT TO PHOTOGRAPH AND RELEASE INFORMATION

Please sign below in ink.

I consent to any and all dissemination of information about me, including photography, film, and /or video of me by and/or for Central Oregon ENT for use in education, advertising, public relations and promotional activities in any and all publications and other media without limitation or reservation. I agree to allow Central Oregon ENT to permit others to use the information, photography, film, and/or video for lawful reasons as stated above. Central Oregon ENT shall retain all information, negatives, film, and video for any future use.

I hereby release Central Oregon ENT and persons employed by the Group from any liability claims, damages or expenses arising from or in connection with the use of such information, photography, film, and/or video of me.

Name (print)_____

Name (signature) _____Date _____

Signature of guardian if subject is under 18 years of age.

Guardian Name (print)_____

Guardian Signature _____Date _____

Address _____

City _____ State _____ Zip _____

Witness Name (print) _____

Witness Signature _____Date _____

Central Oregon ENT 2450 NE Mary Rose Place, Ste 120 Bend, OR 97701 (541) 382-3100